HOSPITALS

Hospital Recovery Room Services
—A Special Section

Circuit Riders in Nursing Education
—Hosford-Pyle

Does Medical Practice Affect Hospital Costs?
—Karl S. Klicka, M.D.

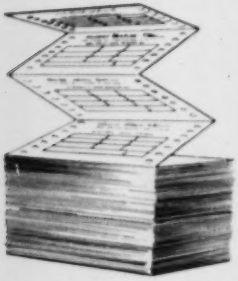
Profitable Results of Employee Training
—Sister Miriam Eveline

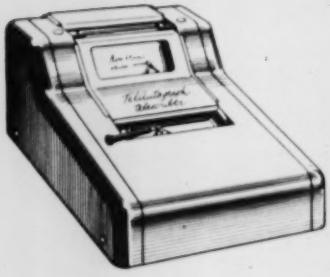
NOVEMBER • 1952

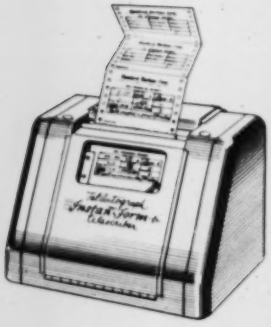
The Journal of the American Hospital Association

The Five Phases Of

Telescriber TelAutograph* Service







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Phase 2	planning design manufacture	to provide the custom-built systems.
Phase 3	installation instruction supervision	to assure proper use and personnel acceptance.
Phase 4	administration usage	to preserve management's control of the System.
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HOSPITALS

IN THIS ISSUE

NOVEMBER • 1952

The Journal of

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VOLUME 26 NUMBER 11

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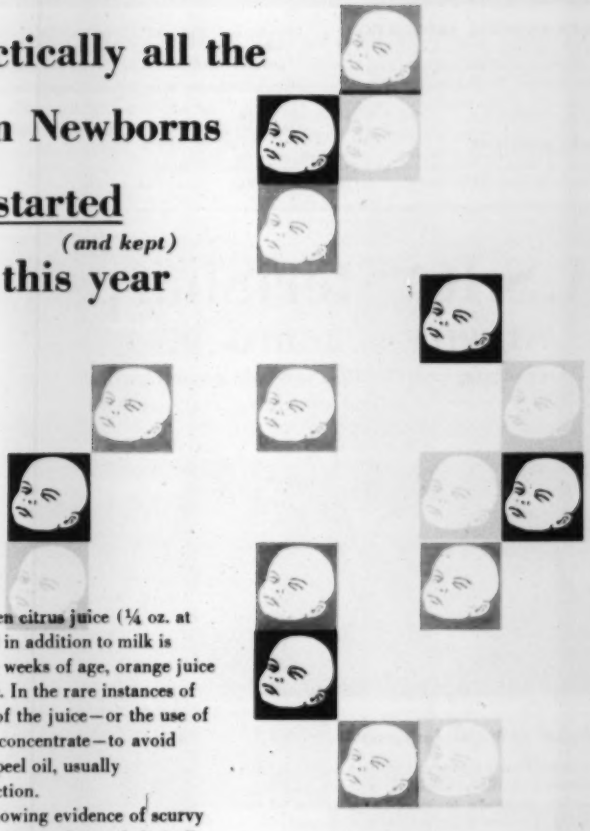

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Midyear Conference of the American Hospital Association—February 6-7; Chicago (Drake Hotel).

55th Annual Convention—August 31-September 3; San Francisco.

REGIONAL MEETINGS

Association of Western Hospitals—April 27-30; Salt Lake City (Utah Hotel).

Maryland—District of Columbia - Delaware—November 10-11; Wilmington, Del. (duPont Hotel).

Middle Atlantic Hospital Assembly—May 20-22; Atlantic City (Convention Hall).

New England Hospital Assembly—March 23-25; Boston (Statler Hotel).

Southeastern Hospital Conference—April 8-10; New Orleans (Jung Hotel).

Tri-State Hospital Assembly—May 4-6; Chicago (Palmer House).

Upper Midwest Hospital Conference—May 13-15; Minneapolis (Radisson Hotel).

STATE MEETINGS

Arizona—February 12-14; Phoenix (Adams Hotel).

California—November 6-7; Santa Barbara (Mar Monte Hotel).

Colorado—November 6-7; Denver (Cosmopolitan Hotel).

Connecticut—November 18; New Haven (Auditorium, Southern New England Telephone Co.)

Florida—November 17-19; Daytona Beach (Sheraton-Plaza Hotel).

Georgia—February 20-21; Atlanta (Atlanta-Biltmore Hotel).

Illinois—November 20-21; Springfield (Abraham Lincoln Hotel).

Kansas—November 6-7; Kansas City (Town House).

Kentucky—March 24-26; Louisville.

Massachusetts—January 20; Boston (Sheraton Plaza Hotel).

Michigan—November 16-19; Detroit (Statler Hotel).

Missouri—November 20-21; St. Louis (Jefferson Hotel).

Nebraska—November 13-14; Fremont (Pathfinder Hotel).

Ohio—April 6-9; Cincinnati (Netherland-Plaza Hotel).

Oklahoma—November 6-7; Oklahoma City (Skirvin Hotel).

Rhode Island—December 13; Providence (Miriam Hospital).

Texas—May 12-14; Galveston (Buccaneer Hotel).

Wisconsin—February 19; Milwaukee (Schroeder Hotel).

OTHER MEETINGS

American Protestant Hospital Association—February 10-13; Chicago (Palmer House).

Canadian Hospital Council — May 18-20; Ottawa (Chateau Laurier).

International Hospital Federation—May 25-29; London, England.

National Association of Methodist Hospitals and Homes — February 11-12; Chicago (Palmer House).

INSTITUTES

(For additional information address Association headquarters, 18 E. Division Street.

Institute on Purchasing—November 10-14; St. Louis (Sheraton Hotel).

Institute for Medical Record Library Personnel—November 10-14; Minneapolis (Radisson Hotel).

Institute on Housekeeping—December 1-5; New Orleans (St. Charles Hotel).

Institute on Laundry—December 8-12; Detroit (Sheraton Hotel).

Institute on Nursing Service Administration—December 8-12; Chicago (Knickerbocker Hotel).

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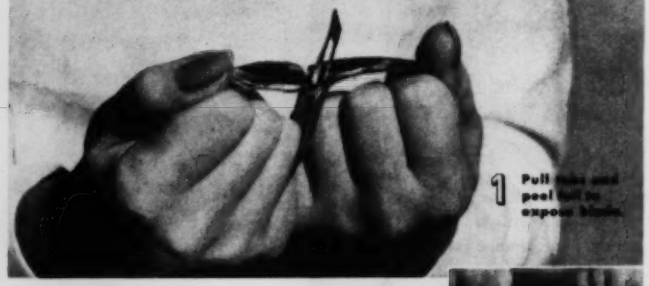

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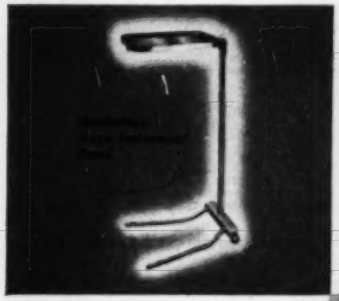

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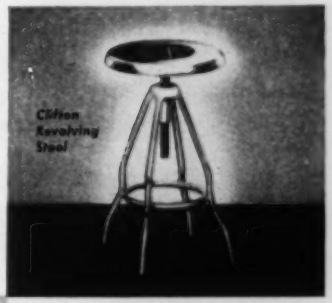

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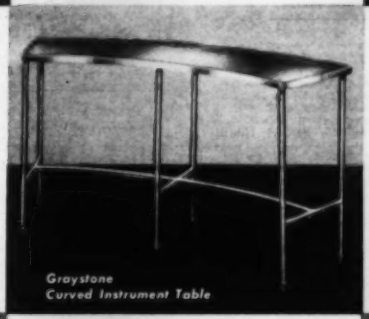

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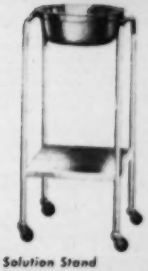

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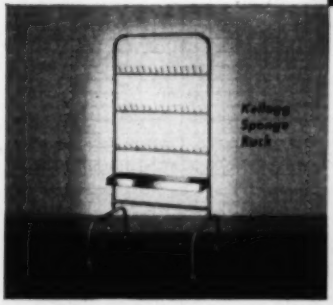

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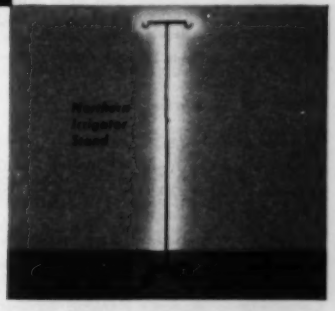

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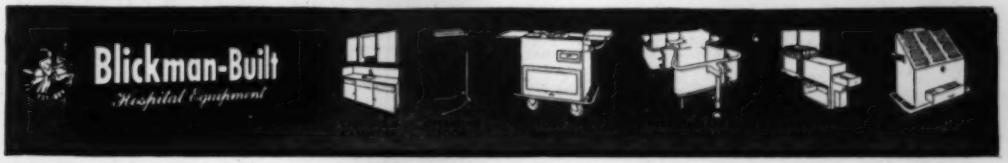

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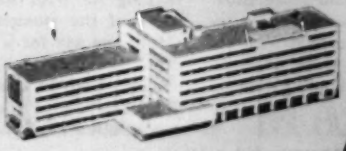

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• Thirty-nine new Veterans Administration Hospitals, in all parts of the country, have chosen AMERICAN labor-saving, automatic equipment for their laundry departments.

Each installation boasts automatic unloading washers and extractors, which save labor and cut washroom costs to the minimum. Automatic folders neatly fold large linens as they come from high-production ironers. Specialized press units speedily machine-iron uniforms, gowns, shirts and other hospital apparel.

Like most of the leading hospitals throughout the world, these V. A. Hospitals are benefiting by AMERICAN'S experience and leadership in the laundry equipment field. Your hospital can benefit too. Write today for our Hospital Laundry Consultant to call.

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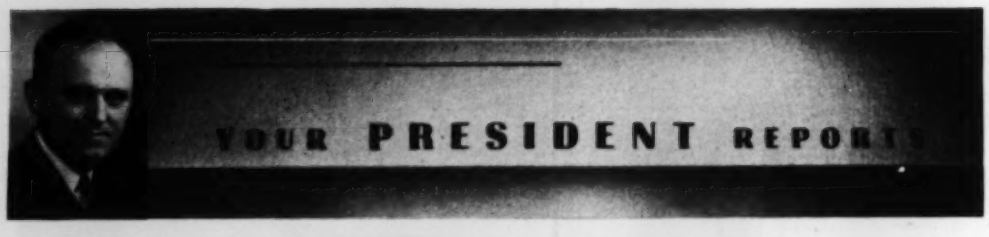

TONY ROURKE HAS indeed laid a firm foundation for President-elect Ritz Heerman and me to start a year of work with the American Hospital Association. His batting average is of such magnitude that Ritz and I will have difficulty in approaching it. We accept the mantle. Tony, the hospitals of the United States and Canada will be forever indebted to you.

This is a real privilege that I have—writing to you folks once a month. I appreciate it. I hope that you will find my notes of interest.

THE 54TH ANNUAL convention in Philadelphia was a fitting climax to a most successful year of Association service to hospitals. More than 12,000 folks came to participate in the sessions, the exhibits, and the social activities. I wish that I might have had more time to attend these sessions, and in particular to see and chat with so many friends who were present. What price glory? It was glorious, though.

THE HOUSE OF DELEGATES did a fine job in electing not only Ritz Heerman—but also re-electing Art Bachmeyer, and putting Bob Hugdens, Tol Torrell, and Gil Turner on the Board of Trustees. Our new coordinating committee, in addition to having the experience of Ray Brown, Jack Masur, and Al Snoke, will have Madison Brown, Bill McNary, and O. G. Pratt. Mrs. Bradford of Columbus will be helping us with the magnificent work of the women's auxiliaries. Could one ask for a better group? Many thanks to Ronald Yaw, Ross Porter, Ken Babcock, and Viola Pinanski. They will continue to assist in other capacities.

All of us are indebted to the staff of the Association for the magnificent manner in which the whole convention was integrated to provide such a wonderful educational opportunity for hospital folk from all over the land. It was my privilege to see this staff at work. I don't know when I have seen such devotion and effort given by so few to so much. They are already evaluating, studying, planning for next year's convention in San Francisco. Plan to get to California on your vacation and attend the meetings. I know that they will be worth your while.

WHAT A YEAR THE Association has to look back upon—the initiation of so many projects beamed at better care for the patients in our hospitals; a study of means of financing this care; an institute for research and education in hospital affairs; a commission of the five major associations in medical and hospital matters for the establishment of standards of patient care and the accreditation of hospitals—to name but three of the important ones.

It is a real thrill to tell you that the Joint Commission on Accreditation of Hospitals has opened its offices at 660 Rush Street in Chicago and is now a going concern. It was difficult for the Crosby family to leave Baltimore and the Johns Hopkins Medical Institutions where three of us had been for al-

"Little Diacks" SINCE 1909

The little tubes that have saved thousands of lives throughout the world.

They check sterilization, which checks infections, which makes for quick recovery, and everybody loves them!

Made by the reliable manufacturers

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Crystalline Procaine Penicillin G in aqueous suspension

The Brist-O-Matic Disposable Syringe containing free-flowing Flo-Cillin Aqueous provides a measured dose of procaine penicillin G, completely sterile, instantly ready for injection under all circumstances.

Constructed of polyethylene and completely self-contained, the syringe is contamination-proof and unbreakable. Because Flo-Cillin Aqueous requires no refrigeration, the Brist-O-Matic Syringe unit can always be kept handy for emergency use. Low cost assures its practicality for one-time use, which in turn eliminates any risk of hepatitis transfer.

The BRIST-O-MATIC disposable syringe containing Flo-Cillin Aqueous is supplied as a complete unit in single sterile packages, boxes of 25. Two dosages are available:

600,000 u. Procaine Penicillin G in 1 cc.

1,000,000 u. Procaine Penicillin G in 1.7 cc.

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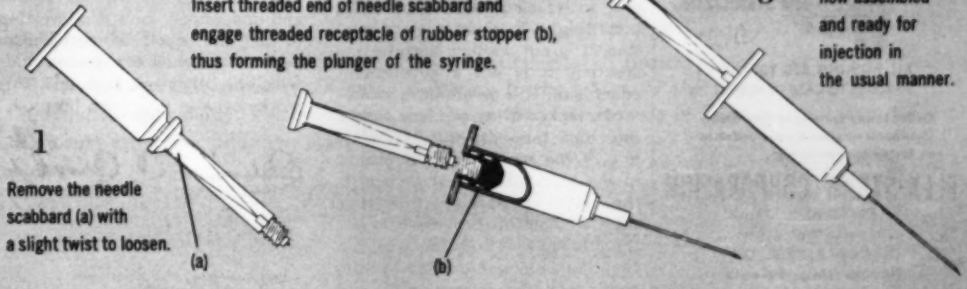
TO USE, SIMPLY: ▼


1
Remove the needle scabbard (a) with a slight twist to loosen.
(a)
2
Insert threaded end of needle scabbard and engage threaded receptacle of rubber stopper (b), thus forming the plunger of the syringe.
(b)
3
The syringe is now assembled and ready for injection in the usual manner.

The Flexible, Sanitary, Disposable Drinking Tube

that revolutionized an age-old hospital custom

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most 17 years and where the two youngest were born, and where we have so many real friends. They were grand to us as we left. We shall never forget the many kindnesses. As Lord Tennyson once wrote, "I am a part of all I have met." Johns Hopkins will always be with us.

I'M DELIGHTED to be here in HOSPITALS with John Hayes. He certainly has much to say in a few words—what my old chief, Dr. Godfrey, called "the acme of sententiousness." Read again what he said about medical social service. It is important to remember as well what medical social service is *not*. It is not the credit office of the hospital assigned solely to determining the eligibility of patients for care at less than cost. So many hospital people still have this misconception.

THE SPIRIT OF cooperation and interest which I have found in Chicago is magnificent. The working together of these groups is typified by a statement made in New York recently by Dr. Gunnar Gunderson, chairman of the Joint Commission and also chairman of the executive committee of the American Medical Association. "In arriving at this great milestone in the history of hospitals and medical care," he said, "the Joint Commission on Accreditation has a great heritage which it accepts with humility, conscientiousness, responsibility, and a determination in its heart to carry on this great work which is unique in the history of the world . . . The Commission realizes that its task is a serious one, to which it must goad itself accordingly. It is not a mere routine, it is not another hospital inspection, it is not a government enactment. *It is a voluntary movement, representing the best thinking, and the best inspiration of five of the most powerful groups in the world dealing with health,* the American Medical Association, the Canadian Medical Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians. We realize what this will mean to the care of the sick and injured of two friendly nations, Canada and the United States . . . It is gratifying that here again the medical profession and hospitals are doing this idealistic task themselves with their own money and efforts . . . It is entirely voluntary and another evidence of the grand work performed voluntarily on the part of our profession and hospital people. I feel it is the most important voluntary movement that could be undertaken." How could it have been said better?

WHEN I visited a hospital recently, I was not only surprised but somewhat shocked to find the administrator smoking throughout the hospital, even in a patient's room. Maybe I'm growing old-fashioned, but aside from fire rules and regulations, it does seem to me that ordinary good manners should tell one not to smoke just anywhere in a hospital—particularly in a patient's room.

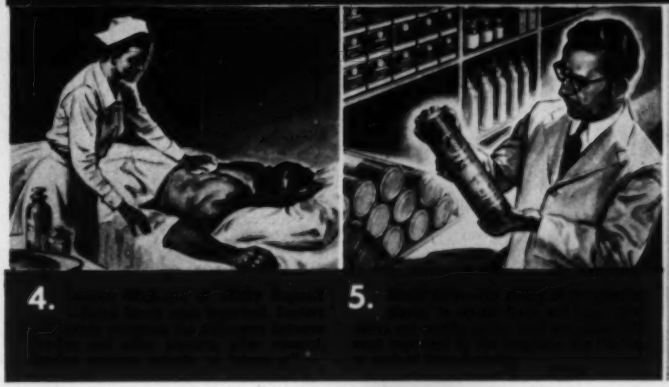
THERE ARE MANY interassociation groups with which the American Hospital Association is affiliated. One of these is the Interassociation Committee on Health, with representatives from the American Dental, Hospital, Medical, Nurses, Public Health, and Public Welfare Associations. It is sometimes most difficult to arrive at a statement which, although agreed to by the representatives present, will also be agreed to by the official policy-making bodies of the parent organizations. In spite of this, however, this group meets faithfully and there is a table and a forum where divergent opinions are expressed—and understood. Isn't it interesting to see the spirit of antagonism melt away when one understands what the other has in mind? This works even in your own hospital.

Edwin L. Crosby

Edwin L. Crosby, M.D., President
American Hospital Association

What Do Hospitals Want Most in an Adhesive Plaster?

(The Results of a Survey Among 1,007 Leading Hospitals)



● Write for a FREE spool of Pro-Cap. Prove Pro-Cap to yourself on each of these 5 points. Make the patch test for skin irritation. You'll never go back to ordinary plaster.

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Judge Pro-Cap on the 5 qualities hospitals want most in an adhesive plaster. Prove it to yourself on the irritation count. If you are allergic to plaster, make a side-by-side patch test on your forearm using Seamless Pro-Cap and any other adhesive plaster.

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Write for Clinical Proof —Write for copies of published medical papers testifying to the action of the fatty acid salts found exclusively in Seamless Pro-Cap.

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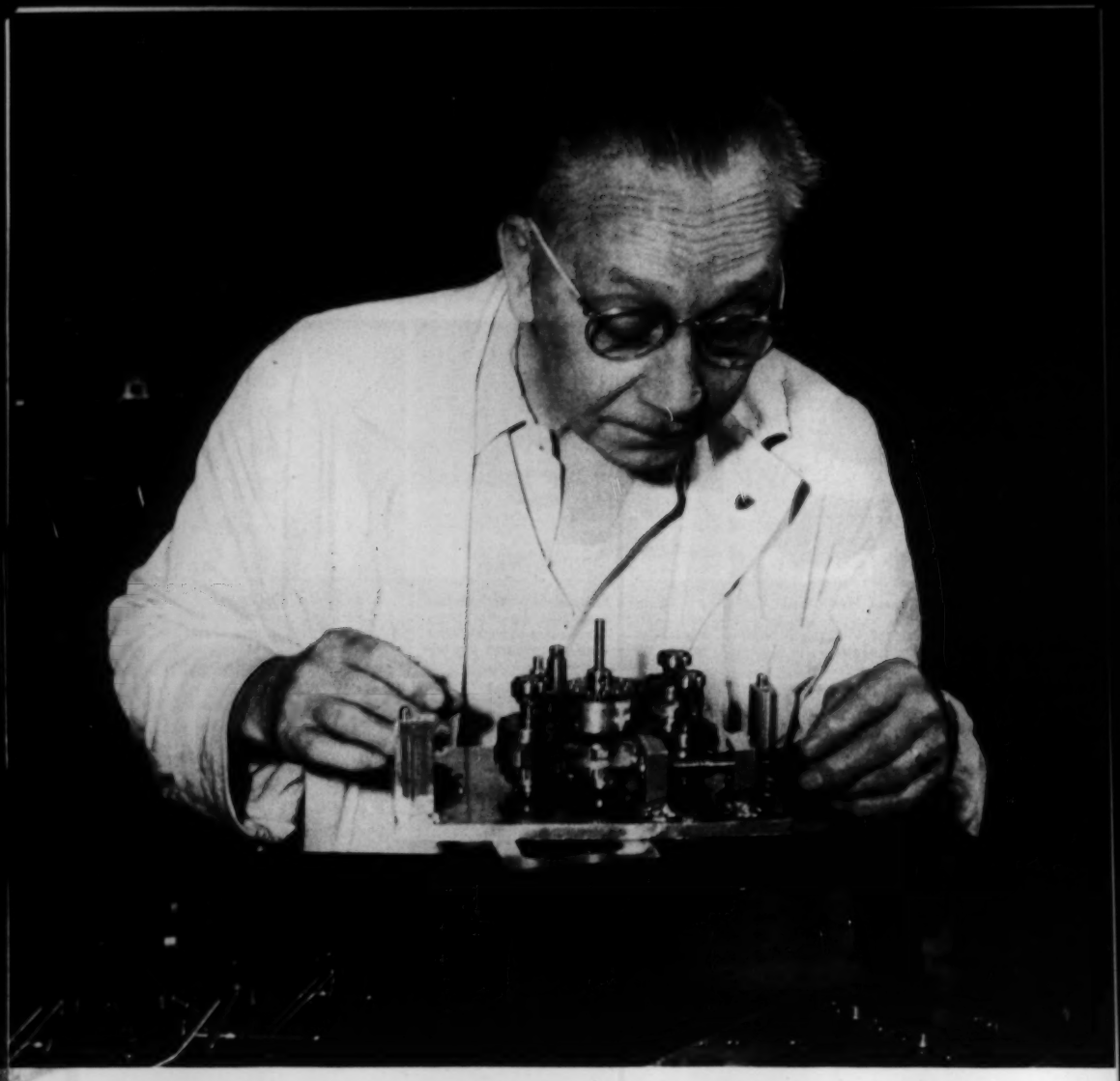

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Ivan (Ole) Burgeson's nimble mechanic's fingers and keen brain have been assisting our engineers in solving x-ray apparatus problems for 31 years. As a model maker, his has been the school of experience for which there is no substitute.

Ole proudly wears the GE Quarter Century Club pin—as do 124 of his fellow-workers whose average 30-year service records total 3746 years. This experience-based craftsmanship has made far-reaching contributions to the enviable reputation that GE x-ray apparatus has enjoyed for over half a century.

Ole and many of his co-workers in General Electric's X-Ray Department are nearing pension age, grown old in *your* service. But they are constantly passing on their experience to many "youngsters" who will be Quarter Century candidates five or ten years hence. Your continuing assurance that

You can put your confidence in —

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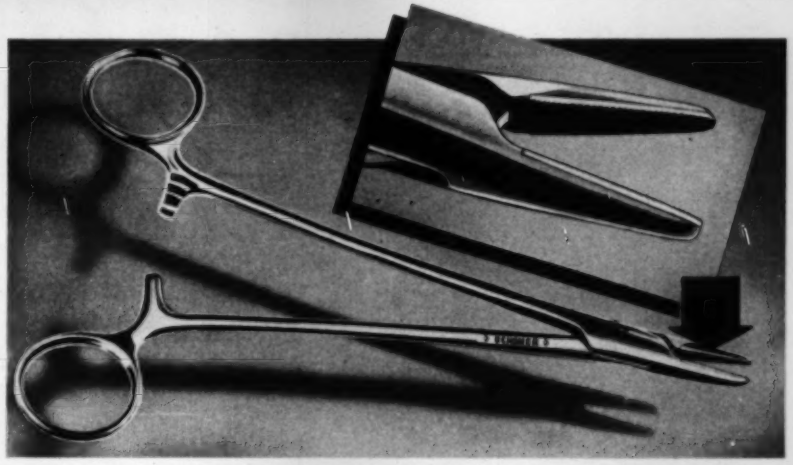

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These long-wearing jaws quickly pay for themselves by greatly reducing repair and replacemnt costs. This is true because their tooth-sharpness is retained many times longer than the softer jaws. In addition to economy, these jaws provide your surgical staff with the utmost in suturing efficiency.

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New Table!
Important Advance!
table top can NOW
be lowered to —
27"

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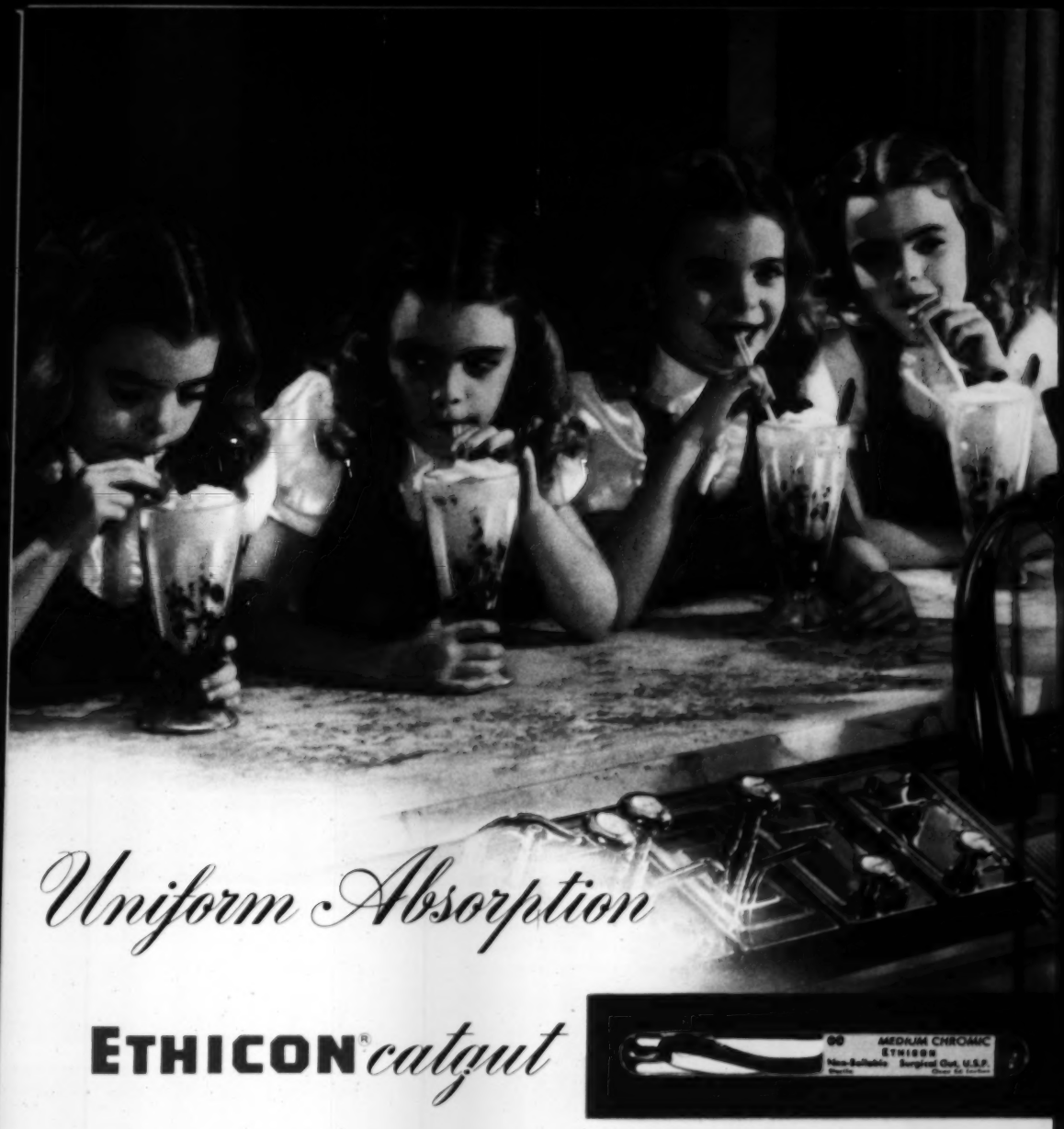

Uniform Absorption

ETHICON® *catgut*

ETHICON Tru-Chromicized Catgut varies less than 10% in absorption time — *regardless of size*. Ordinary surface-chromicized gut varies up to 400%.

The exclusive ETHICON Tru-Chromicizing Process assures the same absorption rate for *all* sizes of Surgical Gut. This unique feature becomes increasingly important to the surgeon as suture size diminishes, for one of the main purposes of fine gut is to minimize tissue reactions.

Because of its relatively larger surface area, fine gut contains more chrome *when processed by the common surface-chromicizing method*—hence may require three to five times longer to be absorbed than larger sizes. Foreign body reactions to such gut are apt to be protracted, with poorer healing, draining sinuses and knot extrusion.

ETHICON Tru-Chromicized Gut eliminates these hazards, since its chrome is evenly distributed *throughout* the cross-section of the strand. Small sizes of ETHICON Surgical Gut may be used with the assurance that they will be absorbed at the proper time, and that repair can proceed without interference.

Temper test

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All ATRALOC Needles fall within this range — one temper throughout, without soft spots or brittleness

TEMPER-TESTED
FOR OPTIMAL STRENGTH AND FLEXIBILITY

ATRALOC® *Needle Sutures*

The Ethicon® electrical tempering method assures *uniform* needle strength; the result is a smaller diameter, yet stronger needle with optimal flexibility and maximum stiffness. For the surgeon, ATRALOC provides outstanding advantages:

- minimal tissue trauma — needle carries single strand
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- eliminates unthreading during operation
- improved points and constant sharpness
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ATRALOC Seamless Needles are needles of choice for general closure, obstetrics, gynecology and most procedures where catgut is indicated.

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SUTURE LABORATORIES AT NEW BRUNSWICK, N. J.; CHICAGO, ILL.; SAO PAULO, BRAZIL; SYDNEY, AUSTRALIA; EDINBURGH, SCOTLAND

3 ways to cut the cost of cardiac care

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lighten your clinic load
reduce cardiac invalidism

"It is practical to maintain large groups of patients with congestive heart failure on a clinic or outpatient status.... The results of our treatment in 125 patients with congestive heart failure with edema who have been followed for the past two years in Cardiac Clinic have been uniformly good with parenteral, oral and rectal Mercuhydrin preparations."[1]

Suppositories MERCUHYDRIN — In clinical experience with MERCUHYDRIN Suppositories, "...only a rare case needed an occasional supplementary injection of MERCUHYDRIN. All patients showed symptomatic and objective improvement and weight and fluid loss.... No toxic effects were observed, and no evidence of rectal irritation was found, even in the presence of rectal or colonic pathology."[2] These 30 patients had previously been receiving 1 to 3 mercurial injections a week.

Tablets MERCUHYDRIN with Ascorbic Acid — The simplest method of outpatient maintenance.

MERCUHYDRIN Sodium — Effective, well tolerated locally and systemically — a parenteral diuretic of choice.

Any patient receiving a diuretic should ingest daily a glass of orange juice or other supplementary source of potassium.

MERCUHYDRIN®

(brand of meralluride)

(1) Riser, A. B.; Kahn, S. S.; Pardue, W. O., and Lawrence, W. E.: Mercurial Diuretics in the Treatment of Congestive Heart Failure, Am. Pract. & Digest Treat. 2:15, 1951.

(2) Levokove, E., and Sarrow, L. A.: Treatment of Chronic Congestive Heart Failure with a New Meralluride (Mercuhydrin) Suppository, New York State J. Med. 51:1410 (June 1) 1951.

Availability — **MERCUHYDRIN Sodium** (meralluride sodium solution) — 1 cc. and 2-cc. ampuls; 10-cc. vials.

Tablets MERCUHYDRIN with Ascorbic Acid — bottles of 100. Each tablet contains meralluride 60 mg. and ascorbic acid 100 mg.

Suppositories MERCUHYDRIN — boxes of 6. Each suppository contains 600 mg. meralluride and 80 mg. sodium bicarbonate in a water-diffusible base.

Leadership in diuretic research

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Two members of the staff of the Mt. Vernon Hospital, Mt. Vernon, N. Y., are shown as their questions are being answered by a professional service representative of Ciba.

E. Weisberger, Superintendent, Cedars of Lebanon Hospital, Los Angeles, Calif., with a Ciba Educational Exhibit in a corner of the staff room.

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A well informed professional service representative of Ciba is always in attendance at the exhibit to answer questions, but no solicitations are made and no orders are accepted. There is no disturbance in the efficient operation of the hospital and no extra work is involved for any member of the hospital staff.

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You are cordially invited to request a Ciba Educational Exhibit in your hospital. A day convenient for you will be arranged if our present schedule permits.

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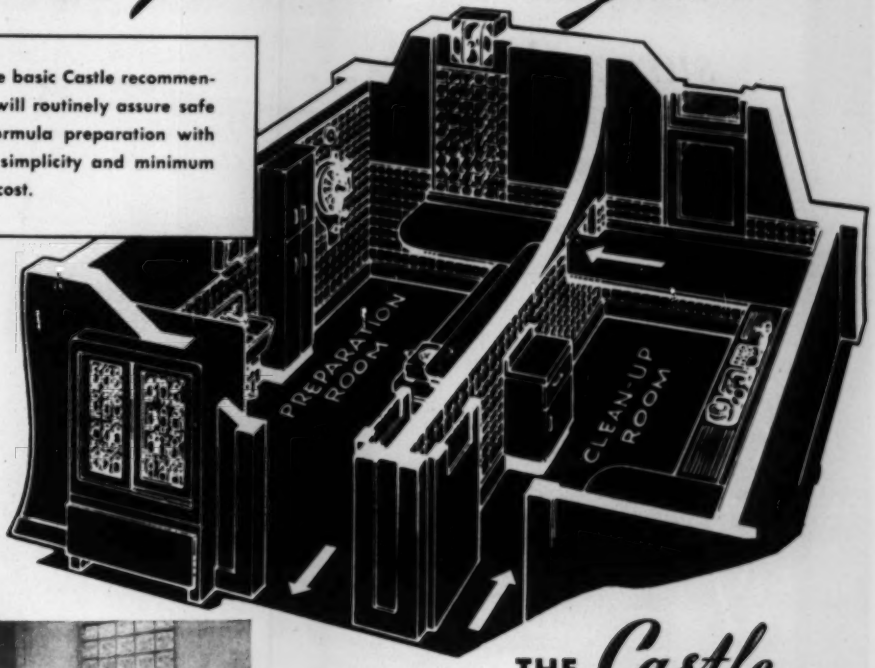
. . . These basic Castle recommendations will routinely assure safe infant formula preparation with greatest simplicity and minimum per-unit cost.



Where practical, as in Castle's recent Genesee Hospital installation, windowed storage refrigeration facilities afford practical supervisory advantages and visitors are happily impressed.

THE *Castle* MILK FORMULA ROOM TECHNIC

● Provides for meticulous cleansing, rinsing and draining of bottles, nipples and accessories within the area designated as the receiving or clean-up section . . . time and cost are saved by terminal sterilization in the concluding process.

● In the preparation section of the Formula Laboratory, terminal heating of bottled and nippled formulas at 230 F. for 10 minutes is sufficient to produce formulas that are bacteriologically safe . . . terminal sterilization permits the use of single door autoclave construction which offers a triple saving in cost, installation and personnel. Its safety concentrates all steps in one simple process.

FACILITIES TO MEET EVERY VOLUME REQUIREMENT

Our experienced Planning Department is available to assist the hospital, the architect or hospital consultant without charge. Planning the Milk Formula Room is an important phase of our business and we welcome your invitation to suggest ways and means most economically practical.

Address your inquiry to **WILMOT CASTLE COMPANY**
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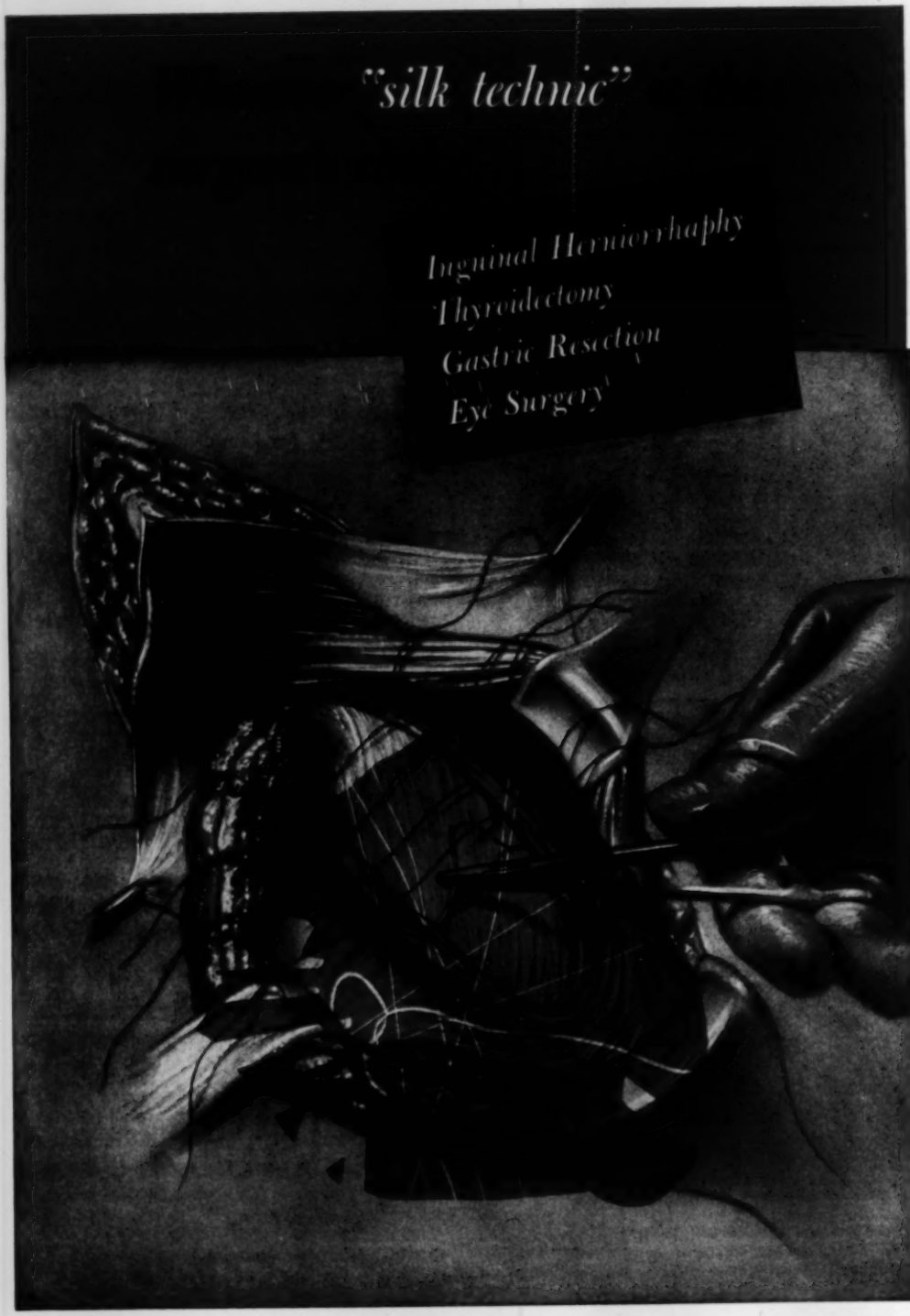
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Inguinal Herniorrhaphy
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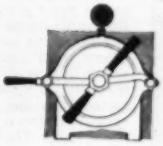
5 *ways better than ever before*

1. Greater tensile strength: One of the strongest silks ever created—smaller diameter sizes can be used everywhere to minimize trauma and foreign body reaction.



2. Withstands repeated sterilization: New Anacap Silk can be boiled or autoclaved *six separate times* without appreciable change in either strength or texture. In laboratory tests almost the full original strength is maintained even after 23½ hours of boiling.

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5. Doubly economical: Low in original purchase price, new Anacap Silk is also low in individual suture cost because of its long sterilization life.

In sizes 6-0 to 5 on spools of 25 and 100 yards; sterile in tubes with and without D & G Atraumatic® needles attached

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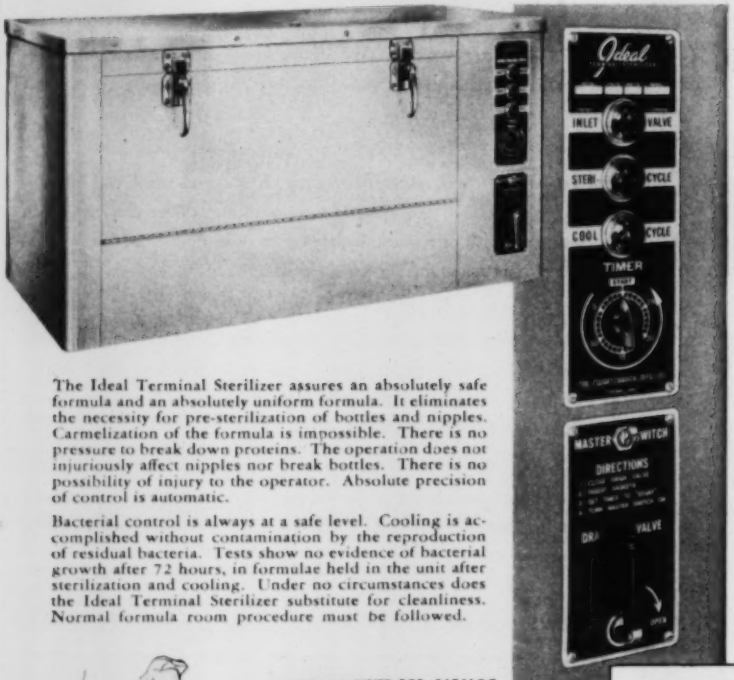
An Outstanding Technical and Economic Achievement

Few other hospital equipment developments in recent years equal the importance of the new Ideal Terminal Sterilizer. This amazing unit provides automatic and unfailing complete control of the bacteria that attack formulae for infant feeding. It also saves its cost many times each year in labor and material cost of infant feeding operations. It enables one nurse to do the work of many in the formula room. It eliminates loss due to spoilage. It saves hours of costly time heretofore spent watching the sterilization process, pre-sterilizing bottles, nipples, etc. It is a positive safeguard against human fallibility.



The Ideal Terminal Sterilizer assures an absolutely safe formula and an absolutely uniform formula. It eliminates the necessity for pre-sterilization of bottles and nipples. Carmelization of the formula is impossible. There is no pressure to break down proteins. The operation does not injuriously affect nipples nor break bottles. There is no possibility of injury to the operator. Absolute precision of control is automatic.

Bacterial control is always at a safe level. Cooling is accomplished without contamination by the reproduction of residual bacteria. Tests show no evidence of bacterial growth after 72 hours, in formulae held in the unit after sterilization and cooling. Under no circumstances does the Ideal Terminal Sterilizer substitute for cleanliness. Normal formula room procedure must be followed.

THE CONTROL PANEL

The control panel in the Ideal Terminal Sterilizer controls the operation of the unit and also informs the nurse or attendant as to the exact status of the operation at all times. When the starting button is pressed the upper green light comes on and remains on until the necessary quantity of water has been injected into the sterilizer. The second phase of the steri-cycle then begins. The red middle light shows that the sterilization is taking place. This red light burns until the sterilization is complete, and then goes out. The upper green light then flashes on and off showing that the inlet valve is opening to admit cold water. The lower green light then appears and remains lighted until the master switch is turned off and the operation of the sterlizer is stopped.

There is no need for haste whe. the lower green light shows that the cooling operation is taking place. The formula will remain safe even if the nurse or attendant is delayed in returning. Only the water passing through the sterilizer is wasted by any delay in switching off the power.

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Found in Foremost Hospitals

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When a vitamin deficiency state exists — as may be the case in old age, with restricted diets, during convalescence, certain chronic illnesses, pregnancy — intensive vitamin therapy may be effectively instituted with

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SPECIAL THERAPEUTIC FORMULA

High Potency Multiple Vitamin Capsules:

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Vitamin D_2 (from ergosterol)	1,000 units
Vitamin B_1 (thiamine) hydrochloride	15 mg.
Vitamin B_2 (riboflavin)	10 mg.
Vitamin B_6 (pyridoxine) hydrochloride	2 mg.
Vitamin B_{12} (cyanocobalamin)	5 mcgm.
Folic acid	1 mg.
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Vitamin C (ascorbic acid)	150 mg.

One or two capsules of PLURAXIN *daily usually suffice*

Available in bottles of 30 and 100 capsules.

*Wilbur, D. L.: Principles in the Use of Vitamins in Treatment: I. Vitamin Deficiency Diseases. Gastroenterology, 1:179, Feb., 1943.

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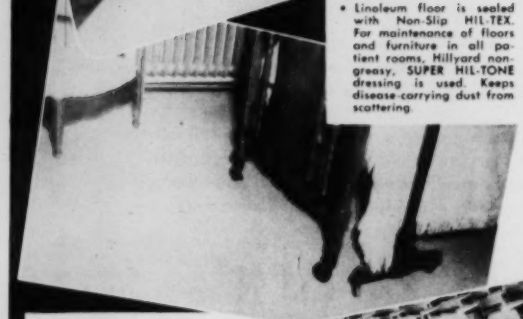

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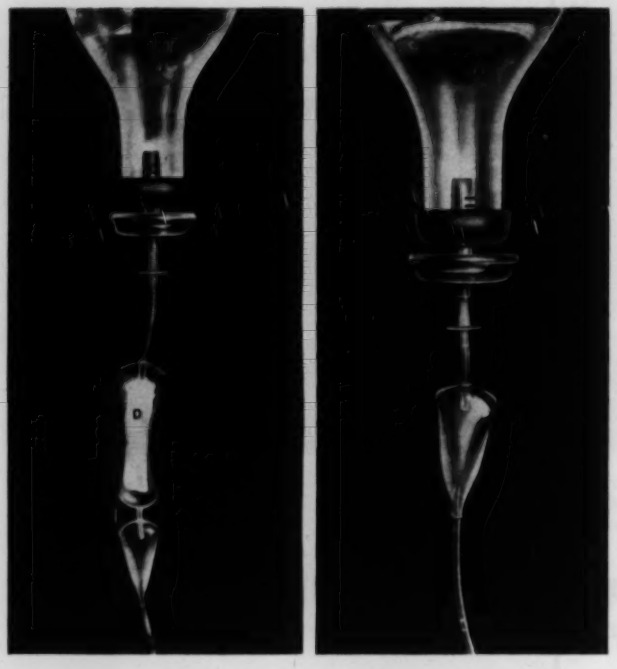

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The Fenwal Plastic Filter Chamber may be gently squeezed to free or break up any blood clots that may tend to clog at the outlet tube or needle.

*Sack, Theodore et al. The Preservation of Whole ACD Blood Collected, Stored, and Transfused in Plastic Equipment. Surg. Gyn. Obst. : 95, 113-119, 1952.
Walter, Carl, W., A New Technic for Collecting, Storage and Administration of Unadulterated Whole Blood. Surgical Forum.
Walter, Carl W., and Murphy, Wm. P. Jr., A Closed Gravity Technic for the preservation of Whole Blood in ACD Solution utilizing Plastic Equipment. Surg. Gyn. Obst. : 94, 687, 1952.

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What are the regulations governing the storage in hospitals of oxygen and nitrous-oxide or other non-flammable gases?

Oxygen and nitrous-oxide may be stored in the same area, but neither of these gases may be put in the same storage room with flammable anesthetics.

The National Fire Protection Association would require conductive flooring in areas used for the storage of flammable gases and ether, which would not be interpreted to include nitrous-oxide and oxygen. Conductive flooring is not intended to be required in storage rooms or rooms housing manifolds for oxygen or nitrous-oxide.

Requirements for manifold rooms are quite thoroughly covered in pamphlet 565 issued by the National Fire Protection Association. This pamphlet covers the piping systems for non-flammable medical gases, since the National Fire Protection Association advises against the piping of flammable gases. Nitrous-oxide is not included as a flammable gas, since its properties are those of oxygen which supports combustion but is not in itself combustible.—ROY HUDENBURG.

Medical record information

What is the policy on transmitting medical record information to third parties?

The question of transmitting information from the medical record to a third party is one that requires careful consideration. The practice of handing over the patient's entire record to a third party is frowned upon by legal authorities.

There are two other parties besides the patient who are interested in the record. These are the physician and the hospital. The record contains a considerable amount of information that is not pertinent to the patient's illness. Some of the information is recorded for the convenience of the physician and some for the convenience of the hospital.

Such items as the family history of the patient, containing data on the patient's father, mother, brothers, sisters or spouses or children are not for the eyes of third parties.

Although the information contained in the hospital record has been adjudged to be the property of the patient, the documents themselves are definitely the property of the hospital. The permission by the patient to divulge the information contained in the record does not automatically confer access to the hospital record.

When a customer requests a company to disclose the price paid for any particular service, the company does not throw open its books of accounting to a third party. It is my opinion that no one outside the medical records department, the attending physician and the administrator of the hospital should be permitted to have access to the complete medical record, unless of course, there is a court order to produce the original record.

Replies to questions by third parties possessing proper authorization should be the sole means of giving out information contained in a medical record. Some hospitals, for the sake of convenience, do turn over the entire file for examination by any third party who has authorization, but this is an undesirable practice that is liable to abuse.—DR. CHARLES U. LETOURNEAU.

Smoke barriers

How useful are smoke barriers in times of fire?

The function of the smoke barrier is to eliminate the need for evacuating patients by means of stairways. That is, the smoke barrier is supposed to divide a patient floor into two sections so that patients can be removed to a haven of comparative freedom from smoke from a section of the floor threatened by fire. This, of course, applies only to fire-resistant buildings with enclosed vertical openings, or two completely sprinkler-protected buildings with enclosed vertical openings. Smoke barriers would perform no function where stairwells and elevator shafts were not enclosed, nor would it be safe to try horizontal evacuation methods in an unsprinklered building of ordinary, that is, wood joist, construction.

I believe that the likelihood of a fire in a patient room getting out of control is rather slim in a well operated hospital. However, the contents of the average patient room are quite sufficient to cause a fire that would make an entire corridor uninhabitable if allowed to get beyond control. The theory of the smoke barrier is well developed in the American Hospital Association Manual on the Development of Fire Emergency Programs.—ROY HUDENBURG.

Hospital-medical charges

We would like to know if it is standard and ethical practice to make separate charges for patients' visits to the hospital and for any professional help rendered to the patients by the physicians in the hospital.

The practice of making separate charges for visits to the hospital and for professional service by the physician is fairly standard in many hospitals. We are not aware that any question ever has been raised about the ethics of such a practice, and there are several variations of this practice. In some instances, the office used by the physician in the hospital is leased by the physician either on a monthly basis or on a per visit basis with the physician rendering the only bill to the patient. In other instances, the hospital renders the bill with the physician contributing his services free or receiving an amount per visit from the hospital. There are complications dependent on all such arrangements from a legal point of view, however, and it would be best to secure the advice from the hospital's attorney if you are in doubt about the attitude of the law.—DR. CHARLES U. LETOURNEAU.

Hospital advertising

Could you please advise us on the Association's policy on paid advertising by hospitals?

Advertising by hospitals has become entirely acceptable; however, it is important that this advertising be handled with the utmost discretion and that no suggestion of competition with other hospitals enter in. The following quotation from an article in the July 1950

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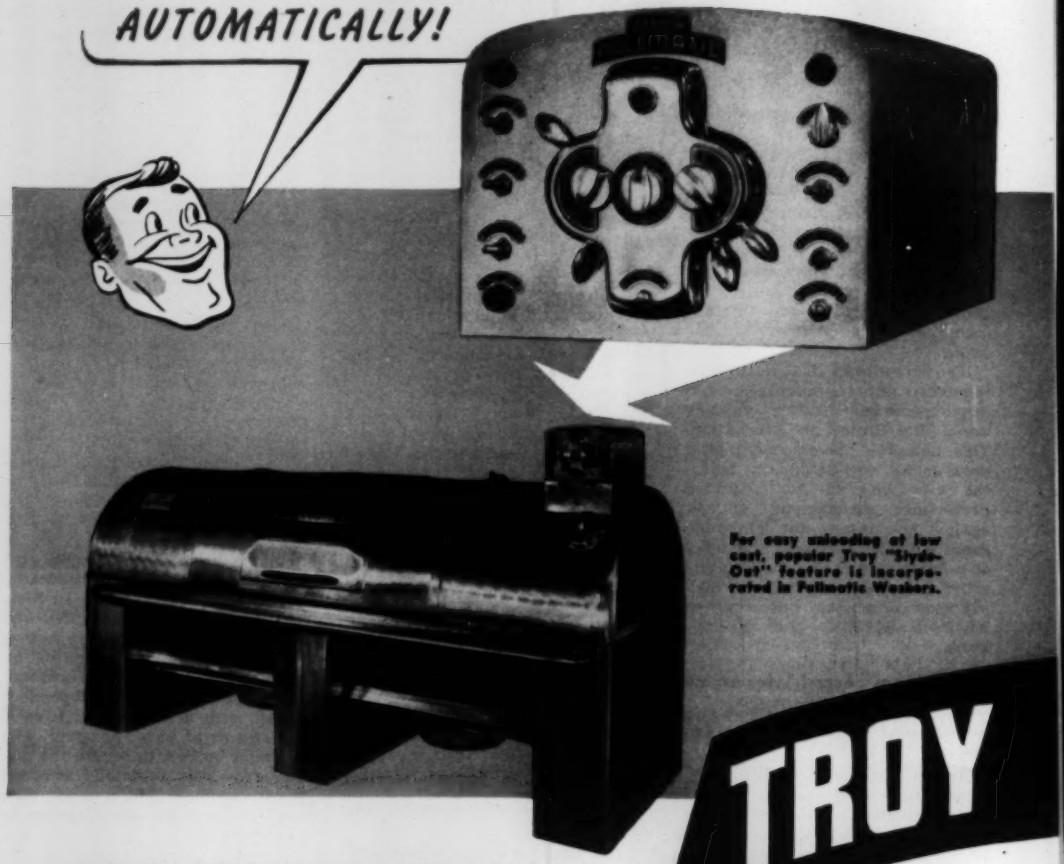

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issue of TRUSTEE, The Journal for Hospital Governing Boards, expresses very well our thinking on this question:

"Advertising should be considered on the basis of what it will accomplish. If the hospital can do a better job in caring for sick and providing better service to the community through advertising, it should be used. The argument that paid space eliminates news coverage is false. Whenever something happens that is news—regardless of whether or not the organization used advertising—it will be published in the press. When advertising, hospitals should be careful not to be competitive. No hospital should give the public the idea that it provides 'the best' or 'better' service and care."—GEORGE BUGBEE, executive director, American Hospital Association.

Ordinarily, hospitals use advertising for two general reasons: (1) To get across to the public information that should reach them quickly, such as a change in visiting hours or a special event such as a lecture, open house, dedication ceremony; (2) To educate the public about long-term needs and problems of the hospital. Examples: Recruiting nurses or employees, stimulating interest among volunteer workers, or presenting annual report statistics.—ANN S. FRIEND.

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Association insignia

Who is entitled to use the official insignia of the American Hospital Association, and how may they use it?

The existing regulations pertaining to the Association's insignia provide for its use only on printed material prepared by affiliated state hospital associations or member hospitals, and this usage is limited by an agreement form signed by each organization to which permission is granted for use. This somewhat formal procedure is required in order to insure compliance with federal regulations concerning use of symbols registered under the Lanham Act, the statute governing the use of emblems such as the Association's official insignia.—HOWARD F. COOK.

Patients-to-physician ratio

We would like to know if there should be any definite ratio of the number of patients per active staff member.

No ratio can be set without considering all the local circumstances of the operation of your hospital in your particular community. Nevertheless, I can quote to you from the study of "Hospital Staff Appointments of Physicians in New York City" carried out by the Hospital Council of Greater New York in 1951.

In this publication, the hospital Council recommends that general care hospitals have as their goal the attainment of an average ratio of beds to physicians on their staffs as follows:

0.90 bed per physician—appointment on the general ward service
0.60 bed per physician—appointment on the private and semi-private services

It should be noted, however, that these ratios are modified when applied to teaching hospitals and to municipal hospitals. I offer the ratios to you with the utmost caution. Before applying such ratios to your own hospital, it would be well to determine whether the circumstances obtaining in your community are similar to those that obtain in New York City.—DR. CHARLES U. LETOURNEAU.

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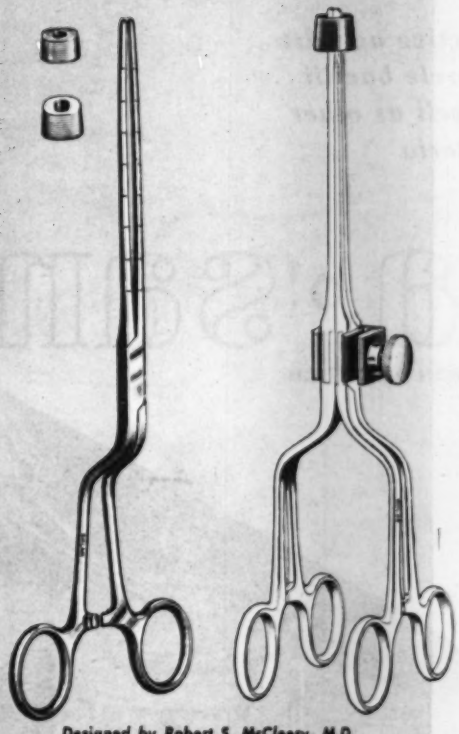

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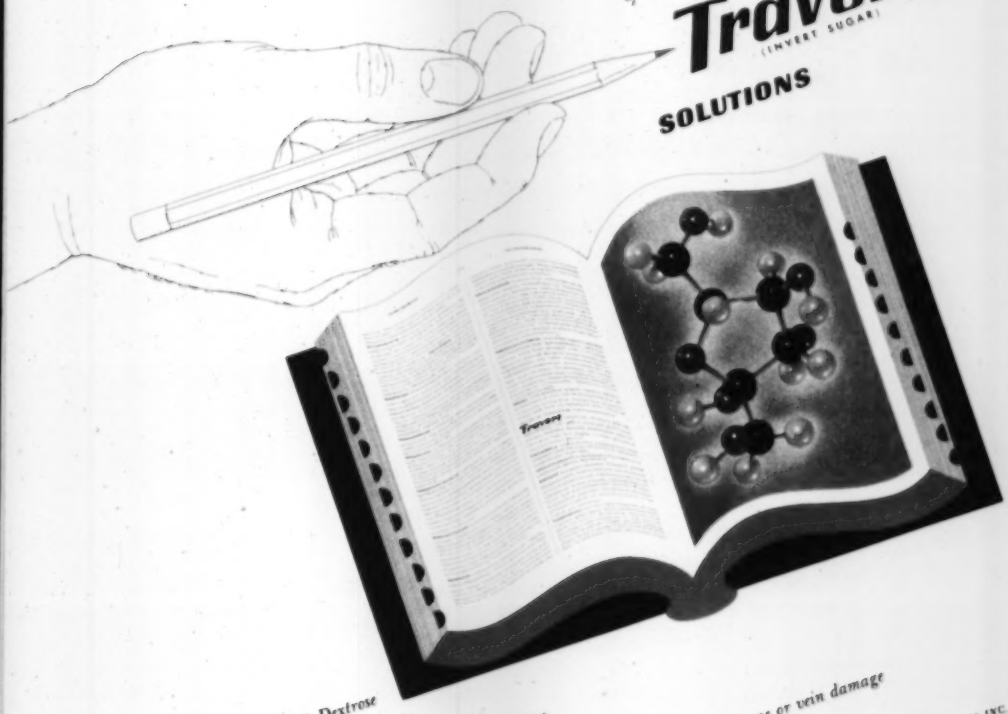

for twice the calories of 5% Dextrose

in equal infusion time

with no increase in fluid volume or vein damage

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. . . in equal infusion time
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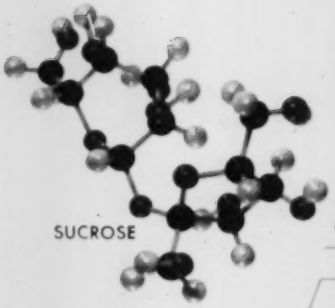

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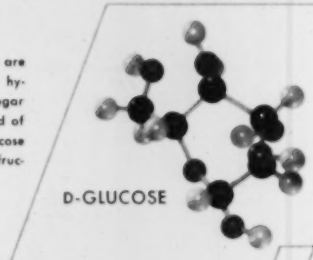

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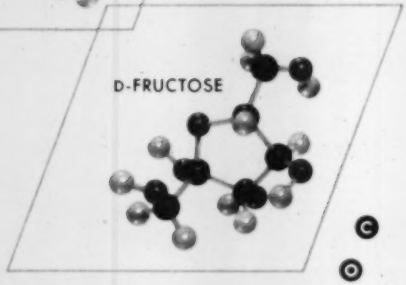

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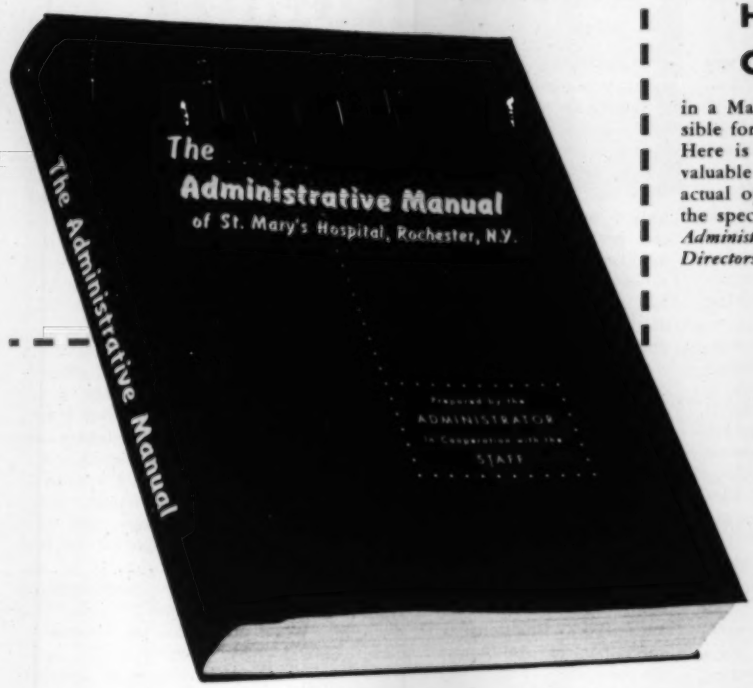

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ON MAJOR PROBLEMS FACING HOSPITALS

NURSING AND FINANCES—these two areas lead all the rest as major problems facing hospital administrators. In a survey of the American Hospital Association's House of Delegates, these two overlapping problems showed up in the returns about three times as often as the problem rated third—the need for unity and cooperation among administrators, physicians, trustees, personnel and the public.

While this survey does not pretend to be a precise measurement of opinion of all the hospitals in the United States and Canada, it does bring out the things that are worrying a number of recognized administrators, and it is unlikely that a complete survey of all hospitals would show results that are appreciably different.

The two top problems, in many ways, go hand in hand, and both have many aspects.

Nursing problems for example, were broken down several ways by the administrators answering the survey. Most frequently mentioned was the shortage of nurses and the need for recruitment. Many administrators expressed concern over the effectiveness of today's education and training programs for nurses, and some expressed fears about the results that nursing accreditation will have. Competition for nurses helped tie nursing and finance together as major problems. Some voiced a long-standing complaint—that hospitals expend the time, money and effort to educate and train nurses, then lose them to the higher salaries of government, industry, health agencies and physicians, who often contribute nothing to nursing education. And the administrators worried about the quality of care their nurses are providing.

The financial worries expressed by hospitals also were many, and they are all related directly to the cost of patient care. Those queried were seeking ways to eliminate or reduce operating deficits and to cut costs without reducing the quality of service. Salaries and subsistence costs are a major problem, particularly with the shortage of skilled personnel and the competition that exists for these workers. Maintenance and plant operation costs are high, and present costs are holding up needed construction and remodeling.

There are problems of reimbursement—from patients, from repayment plans and from governmental and other agencies that buy hospital care. Some members of the House of Delegates listed the unfavorable effects of discounts to employees, doctors and others. Relations with such specialists as radiologists, anesthesiologists and pathologists brought mention of other financial worries. The fluctuating patient census emphasizes the "readiness-to-serve" cost. And several administrators mentioned the importance of explaining hospital costs to their medical staffs and to the public.

Unity and cooperation—this might serve to cover the problem rating third in this survey. One administrator likened the hospital to a military task force, which has a general staff (the board of trustees) which outlines strategy, a commander (the administrator) who helps outline strategy but is responsible for tactics, and the operational and supply units (medical staff and personnel). In a task force, he wrote, all of these units remain highly specialized and yet responsible to central control . . . "to the end that the task force, be it military or hospital, may concentrate on the single task—to overthrow the enemy, be it a military force or disease." It then becomes the responsibility of the administrator to see that each unit is not only highly specialized but geared to serve the community as a unit under his direct command.

Another administrator described what he called "the growing discordant relation of the trustee, physician and administrator." The very existence of hospital and medical practice, he said, depends on the three working together.

Several examples of friction between administration and staff were cited by another member of the House of Delegates. For example: "One doctor whose patient was injured in the hospital became very irate when he learned that a report had to be made to the administrator's office. Another physician, one of the chief officers of the local medical society, is an advocate of a policy that there should be no lay members of boards of trustees of hospitals. An administrator requested a radiologist to keep his department open on Saturday mornings. The administrator was reported to the local radiological society as an example of 'lay administrators practicing medicine.'"

When physicians fail to understand why hospital costs have risen, another source of friction results. "Many patients are completely overcome when they enter a hospital and are told what the daily room rate will be. The blame for the high cost of hospital care seems to be placed more and more in the lap of the administrator. He is accused of inefficiency, waste and extravagance."

Still another way of stating this same problem involving unity is this, from one of the responses: "It is the task of inducing people to work together toward a common predetermined goal."

Many additional problems were mentioned by those who responded to this survey. Government's role in hospital care was mentioned often. Some feared centralization of too much control in

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government. Others worried about government's competition for skilled personnel—for example, veterans hospitals offer attractive salaries and pull nurses out of surrounding institutions. The entire system of veterans medicine brought comments from administrators who feel strongly that Congress should eliminate or at least limit veterans hospital care for patients with nonservice disabilities.

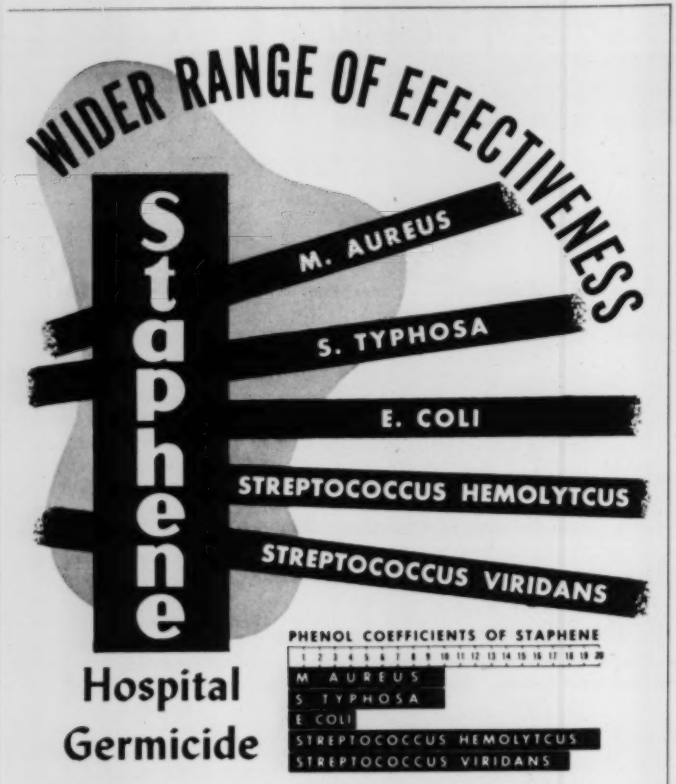
Now that great progress has been made in the fight against the diseases that have taken heavy tolls in the past, care of the aged and the chronically ill has become a major problem, and this fact was indicated on the survey returns. Administrators are wondering how and in what kind of facilities these patients can be cared for properly, and they are wondering also where the money will come from.

One administrator asks, "Are the voluntary hospitals going to assume the responsibility for this care (of chronically ill and the aged), and if so, what plans are being made to solve this ever increasing public health problem? . . . Are nursing and convalescent homes the answer? If yes, then who will set the standards for this type of institution in order that they will be safe places for the care of the sick? If this is not the answer, certain facts must be faced in order to assure adequate care for the chronically ill and the aged infirm. We must determine, first, who is responsible for the care of this unwanted patient; second, in what type of institution this care should be administered, and third, who will finance the cost of such care."

Some administrators thought that the primary problem was in administrating itself—the need for improvement in the general management of hospitals. "Hospitals have fallen far behind improvements in medical practice, technological and architectural developments," wrote one administrator, "and in particular have not kept pace with business and industry in the application of scientific management methods to the increasingly complex operation of the hospital."

Another response cited "the lack of exact standards for the measurement of workloads, personnel requirements and manpower productivity" as the Number One problem confronting hospitals. Inexactitude of staffing yardsticks, he wrote, invites occasional "padding" of requirements by department heads as a cushion against expected "cuts" from above; arbitrariness of management in imposing ceilings on expenses; poor distribution of available manpower; and tolerance of uneconomical methods of operating the hospital.

These problems summarized above led the list in the HOSPITALS survey. There were many other problems mentioned (rehabilitation, care of the mentally ill, participation in community health matters, the need for all types of personnel, competition between hospitals and needless duplication of facilities), and the fact that these problems were mentioned infrequently does not necessarily make them unimportant.



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As each glove is pulled from a sorting pile, other gloves in the lot are disturbed so their size markings come *instantly* into view. With workers scarce and costly, this time-saving PIONEER Multi-Sizing is an important factor in reducing your labor budget.

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For complete facts and figures on Honeywell controls for your hospital, call your local Honeywell office – there are 91 of them located in key cities. Or for literature, write Minneapolis-Honeywell Regulator Co., Dept. HO-11-27, 351 E. Ohio St., Chicago 11, Illinois.

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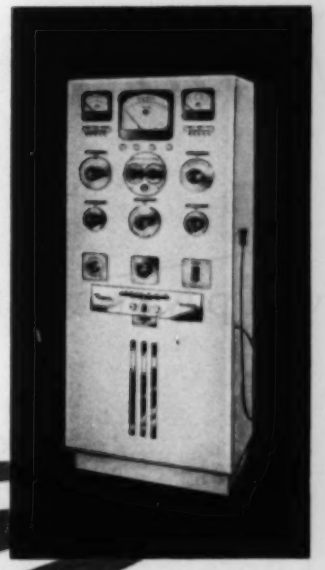

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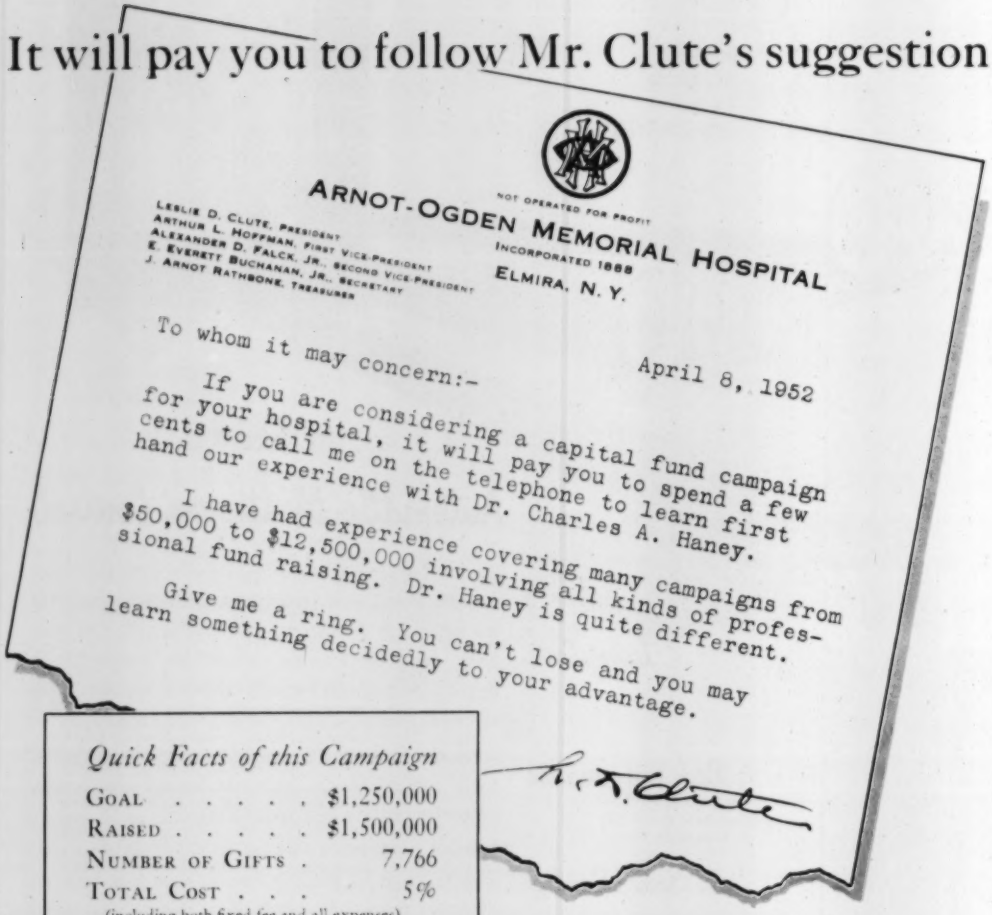

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April 8, 1952

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I have had experience covering many campaigns from $50,000 to $12,500,000 involving all kinds of professional fund raising. Dr. Haney is quite different.

Give me a ring. You can't lose and you may learn something decidedly to your advantage.

L. T. Clute

Quick Facts of this Campaign

GOAL	$1,250,000
RAISED	$1,500,000
NUMBER OF GIFTS .	7,766
TOTAL COST . . .	5%

(including both fixed fee and all expenses)

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Specialists in Successful Fund Raising for Hospitals for nearly 30 Years

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Announcing....

a new portable Hausted examining and O. B. table...

Received with greatest acclaim ever awarded a Hausted. Without removing patient the examining table is converted in five seconds to Mobile Stretcher. (See illustrations) With available accessories this is the most revolutionary—versatile and useful stretcher and examining table, for every conceivable purpose. Ideal for clinics, doctors' offices, as well as hospitals. "*One time handling—Gentle Handling*"

Write for complete descriptive data and time studies showing how all Hausted Wheel Stretchers are obtainable at a cost of 0 $ minus. (This means that Hausted equipment makes a profit for your hospital.)

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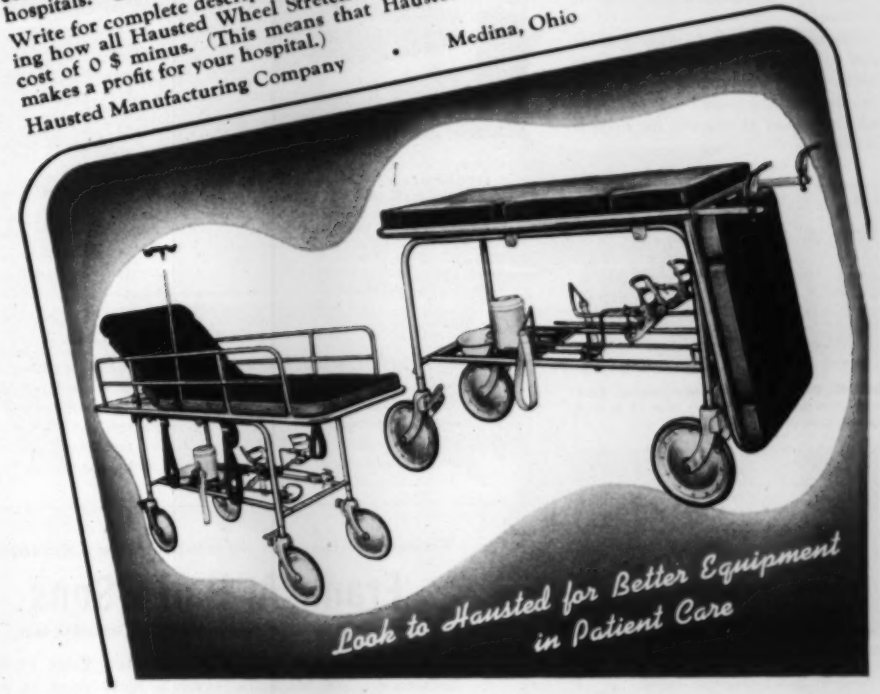
Hausted "Gentle Handling" WHEEL STRETCHERS



Revolutionary
Sani-Pan-Comfort Bed

Eliminates Discomfort, Vastly Eases Nursing Burden

Patients Now Given Showers While in New Nylon and Foam Rubber Quick-Drying Utility Beds

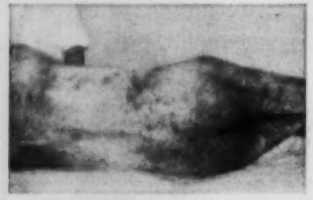
The new *Sani-Pan-Comfort Bed* (developed by a doctor) manufactured by Frank A. Hall & Sons is revolutionizing the care of cardiac, neurological, genito-urinary, orthopedic and senile cases. It is also ideal as a pack-bed for extensive burn cases and most post-operative situations.

A heavy Nylon sheet firmly attached to two side rails forms the "upper" mattress of the new bed. A crank allows this sheeting to be regulated for firm or loose support. A foam rubber mattress operates in unison with this sheeting and provides added support. In the center of the Nylon "upper" mattress, a 12-inch reinforced slit, below which a bed pan is placed, permits automatic drainage of all fluids.

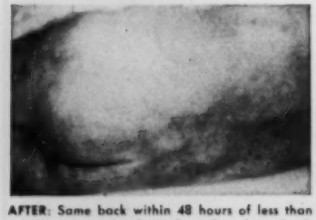
The result is a bed of utmost comfort that will be dry 10 to 15 minutes *after being under a shower*, that is simple to clean and completely odorless even with the most chronically incontinent patients.

ABOVE: The Hall *Sani-Pan-Comfort Bed* in which Nylon and foam rubber completely replace the usual steel bed springs, hair mattress, rubber sheet, draw sheet and bed sheet. A comfortable, no-lump, wrinkle-free, always dry and well aired utility bed is the result.

INSET: Positioning pan from the side. Note reinforced slit in Nylon sheeting for automatic drainage.



BEFORE: During test at a State Hospital. Back with urine rash and bed sores after 12 days of routine care in conventional bed.



AFTER: Same back within 48 hours of less than routine care in *Sani-Pan-Comfort Bed*. "Diseased" back is completely healed.

Report from a State Hospital

At a State Hospital, where the *Sani-Pan-Comfort Bed* has been in use on wards for over three years, the following conclusion was reported after a carefully controlled experiment:

"...*The Sani-Pan-Comfort Bed* makes good nursing easier and better, prevents and cures urine rashes and bed sores, eliminates hard nursing chores, such as lifting patients on to bed pans, or into bath tubs, saves medication costs, mattresses, sheets, and springs."

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Formula: Each 30 Gm. contains:

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Riboflavin (B_2)	1.50 mg.
Niacinamide	3.50 mg.
Vitamin B_{12}	30 micrograms
Pantothenic Acid	1.25 mg.
Pyridoxine Hydrochloride (B_6)	0.15 mg.
Biotin	9.00 micrograms
Inositol	23.00 mg.
Choline	60.00 mg.
Calcium	29.00 mg.
Phosphorus	100.00 mg.
Iron	2.40 mg.
Calories	120.00
FOLVITE* Folic Acid	1.5 mg.

LEDINAC Liver Protein Hydrolysate *Lederle*
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Relatively safe, controlled individual dosages of rectal PENTOTHAL may be given to attain levels from preanesthetic sedation or hypnosis to basal anesthesia. It may serve as a valuable adjunct to general anesthesia and, frequently, as the sole agent in a variety of short, minor procedures.

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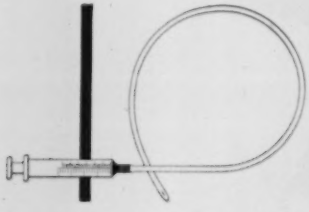

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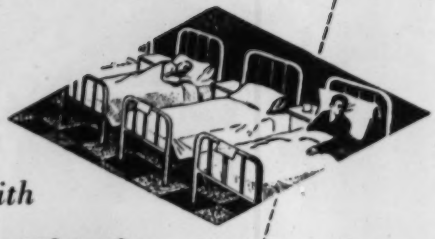
surgical patients home sooner with



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Prostigmin usually restores normal intestinal motility quickly so that patients are back on a full diet sooner. With their strength restored, they are up and ready for discharge in a shorter time. Its tonic effect on bladder function keeps catheterizations at a minimum.

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Prostigmin® is backed by more than 3,000 scientific publications. It is the *tried and clinically proved* neostigmine preparation.

Six schools of nursing in northwestern Pennsylvania solved the problem of giving their student nurses training in the sciences by setting up an itinerant staff of college laboratory instructors.

CIRCUIT RIDERS in nursing education

RAYMOND F. HOSFORD
AND
HUGH G. PYLE

THE TREMENDOUS STRIDES made in scientific medicine within the last 25 years have brought with them the need for change and improvement in all phases of hospital operation. Most noticeable in this kaleidoscopic, evolutionary period have been the demands upon nurses to perform new and more complex nursing procedures. These in turn have resulted in the need for improved standards in the field of nursing education. Few if any experienced hospital people will disagree with these broad statements.

In considering the method and degree of improving nursing education there is a wide area of difference between those educators whose thinking is along the lines of the Brown Report[1] and those medico-hospital people who are directly responsible for the treatment and nursing care of the patient. With an acute shortage of nurses prevailing on a national scale, the situation is complicated by the law of supply and demand.

The educators are demanding that nursing education be placed in the hands of colleges and universities whose primary purpose is education. That would probably result in the closing of many existing schools of nursing. The medico-hospital group is convinced that this would create a dangerous shortage in nursing service for hospitals and communities outside the teaching centers. They feel that the educators' approach seems to make nursing education an end in itself rather than a means to an end, the end being to provide adequate bedside nursing service to the sick and injured and capable nurses to serve in supervisory, teaching, public health and other specialized capacities. They wonder if it would be wise to require every school to be qualified to teach at the college level when the present three-year schools are turning out well-qualified bedside nurses, some of whom have neither the capacity nor the desire to advance beyond that point.

Ginzberg[2] has pointed out that when the cadet nurses program

Mr. Hosford is director, Lankenau Hospital, Philadelphia, and former director, Bradford (Pa.) Hospital. Mr. Pyle is supervisor, informal instruction division, Pennsylvania State College.

1. Brown, Esther Lucile, Nursing for the Future. Russell Sage Foundation, 1948.

2. Committee on the Function of Nursing, Eli Ginzberg, chairman. A Program for the Nursing Profession. The MacMillan Company, 1949.

was in operation, "While communities of 500,000 or more comprise 17 per cent of the total population of the country, they contributed only 9.5 per cent of the total cadet nurses whose training was subsidized as a wartime measure by the federal government. Communities of 25,000 or less, comprising 23 per cent of the population of the country, accounted for almost 45 per cent of all cadet nurses. These outlying areas would probably yield good results, especially if training schools could be located in the vicinity of the students' homes."

RECRUITMENT AREAS

If the experience of cadet recruitment applied similarly to general nurse recruitment it would seem logical to conclude that the larger cities must be dependent on securing substantial numbers from the smaller communities to meet their nursing requirements. Conversely, a large percentage of young women from the smaller communities would probably remain in the general vicinity of the teaching centers after completion of their training. Then the cost to the student also becomes a factor. Without financial aid, many prospective students might not find it possible to enter schools of nursing in cities where expenses would be greater than in or near their home community. Were community colleges more common in the country today, this need might be better served.

Despite the critical shortage of nurses, one group of educators is demanding that "socially undesirable" schools of nursing be eliminated. As stated in the Brown Report, "If hospital boards will not themselves put an end to unsatisfactory schools, it seems essential that strong external pressure be exerted on those whose schools fall below certain standards, either to effect necessary changes within a designated time or to close their training units. This is supposedly one of the functions of the state boards of nurse examiners."

There is widespread difference of opinion as to what constitutes a socially undesirable school. Obviously standards must be sufficiently high to insure turning out nurses capable of interpreting and carrying out doctors' orders. Today many schools which some educators would class as socially undesirable are turning out nurses entirely satisfactory to the great majority of doctors and hospitals.

The debate goes on and on, while external pressures are being progressively increased on the smaller hospital-operated schools.

One of the most trying problems for the small community school is the difficulty in securing qualified instructors, particularly those to teach the science subjects. Some schools located in close proximity to a college or university have sent their students to these institutions for their preclinical training. This was not practical for six hospitals[3] operating schools of nursing in northwestern Pennsylvania where population is sparse and where there are few such institutions. Unless an instructor had home ties in the area, it was difficult to attract them to these locations. This was simply the result of the shortage of instructors. The Brown Report stated, "In general, effort was made to visit 'better' schools in every region . . . Of the schools visited in the late summer of 1947, scarcely one had been able to complete its teaching roster for the September term . . . many positions went unfilled by nurses who failed to have the qualifications desired."

Some of us tried to improvise to meet our teaching problem, just as some of the "better" hospitals must have had to do. We employed on a part-time basis well qualified science instructors from local high schools. The special application of the subjects to nursing was carefully worked out in advance by the instructors and directors of nursing. Many of us thought that reasonably satisfactory results were obtained, but the Pennsylvania State Board of Nurse Examiners refused to let us operate in this manner. There was constantly hanging over our heads the fear that our hospital might be the next to receive an ultimatum prohibiting us from taking a new class into our school until all technical requirements had been met. Our hospitals wanted to operate good schools; they were desirous of improving standards—but how?

An intensive search for a solution was begun and many different schemes were carefully studied. None of the successful plans seemed applicable to our geographical location. Finally, our problem was taken to the general extension services of the Pennsylvania State College. The college officials already were aware of the situation, as a hospital school near the college had recently been forced to close and the college even then was lending teaching assistance to another neighboring hospital school. Despite the sympathetic response which the college people gave to our appeal, there appeared to be no practical solution to our problem. The groundwork was laid, however, for a series of conferences which continued over a two-year period during which all phases of the situation were thoroughly studied. To this series of meetings the college invited representatives of hospitals interested, representatives of the Pennsylvania State Board of Nurse Examiners, the Pennsylvania State Nurses Association, the League of Nursing Education, the public school nursing group and representative staff members from the college.

PLANNING CONFERENCES

The first plan considered in these conferences called for two 12-week programs of instruction in each of two summers, to be given on the Penn State campus. This proposal was not feasible for two reasons: (1) Because of cost involved (the hospitals had idle board and room facilities during this time); (2) because the State Board of Nurse Examiners did not approve of deferring the preclinical instruction which the college proposed to give until the second summer.

The general extension services at the college had had satisfactory experience in its management training program with an itinerant staff of instructors. In fact, the traditional objective of the extension service is to offer programs of instruction when, where and as desired by homogeneous groups of persons in Pennsylvania.

At a regular meeting of the state board in June 1951, the board

3. Altoona Hospital, Bradford Hospital, Sharon General Hospital, Clearfield Hospital, Lewistown Hospital, Oil City Hospital.

readily approved a plan under which the college would set up an itinerant staff which in a 12-week summer period would teach the science subjects of the preclinical curriculum. The plan called for early recruitment of student nurses and their consequent enrollment in hospital schools in June rather than in September. The hospitals felt that this was not a great problem and readily secured complete cooperation from high schools concerned.

PROGRAM FEATURES

Features of the plan presented to and adopted by the six hospitals were these:

1. Instruction would be given in anatomy and physiology, chemistry, microbiology, psychology and sociology.

2. The 12-week period would start Monday, June 16, and close Friday, September 5.

3. In almost every instance a greater number of hours of instruction would be offered under the plan than had previously been the case. The program accepted was as follows:

	Hours	Hours per week: Recitation	Hours per week: Laboratory
Anatomy and physiology	120	4	6
Chemistry	84	2	5
Microbiology	84	2	5
Psychology	24	2	—
Sociology	24	2	—
Total	336	12	16

4. The college indicated that it would send members of its staff to inspect laboratory facilities for these courses in each hospital school and in some instances it was necessary to transfer the instruction to a local high school laboratory. Where needed, equipment was made available from college laboratories.

5. The staff ultimately selected by the college consisted of three instructors in anatomy and physiology, two in chemistry, two in microbiology and two in psychology and sociology. Subject matter supervisors from the college staff aided in the planning and outlining of instruction given.

6. Under the plan, the college also initiated a uniform series of tests to help plan its course of instruction and to aid participating hospitals in the selection of student nurses. Test results were also used for comparative purposes among the six hospitals.

7. The teaching load for the staff was relatively heavy. In anatomy and physiology, 20 hours per week were scheduled, including four hours of recitation and six hours of laboratory instruction in each of two hospitals; in chemistry, 21 hours per week, including two hours of recitation and five hours of laboratory work in each of three hospitals. Microbiology instructors had the same schedule, and in psychology and sociology each instructor had a load of 12 teaching hours per week. Estimated weekly travel for the instructors in order to meet their classes varied from 180 to 509 miles.

8. In order that the program might have a maximum of efficient instruction, the state board required and the college strongly approved of a nurse coordinator for the program being employed by the college. The duty of the coordinator was to check on the overall aspects of the program primarily for the purpose of assuring the college that it met in all its details with the needs of student nurses and the hospitals. She has worked closely with instructors, hospital staff officers and students in connection with the program.

9. The cost to each hospital was $4,800. This charge includes the following costs: Instruction; administration of program; supervision of instruction; travel expenses, with hotel and meals included; the cost of certain teaching materials such as charts and mimeographed items; needed visual aids and so forth; secretarial help; the expenses of the coordinator's office; supervisory travel; the cost of the testing program.

SATISFACTORY RESULTS

As this is written, with the program more than two-thirds completed, both the six participating hospitals and the college have indicated complete satisfaction with the operation of the plan. This program, entailing a total of 40,000 miles of instructor and supervisory travel in a 12-week period, has been carried on for a total of 151 student nurses in the six participating hospitals. The average total cost per student to all the hospitals for this program was $192, but the cost to individual hospitals varied between $165 and $218 per student.

COLLEGE INSTRUMENTAL

In the case of almost every hospital, the college has been instrumental in improving laboratory facilities as well as the level of instruction, and it is prepared to work with the six hospitals to aid further in this respect. The coordinator of the nursing education program has provided outstanding assistance in a continuing analysis of the effectiveness of the program and in giving careful attention to the operating details of the project. She plans to continue throughout the year in a series of contacts with cooperating hospitals for the purpose of integration of the science program into the training of the student nurses.

INTENSIVE INSTRUCTION

It is believed this program is unique among hospital schools. The program of instruction for the student nurse is intensive—28 hours of lecture and laboratory work per week—yet college staff members are enthusiastic over results achieved. Science subjects are commonly considered to be among the most difficult in such curriculums. One staff member employed for the program from another large university stated that he was returning to his campus with entirely different standards in mind which his university freshmen should achieve in 18 weeks. Ratings at the conclusion of the program will enable each hospital to know exactly how each individual stands in a particular subject, not only in her own class but in the composite group of all six classes in that subject.

Meantime, in a larger sense the program has enabled these small town communities to raise standards for their hospital schools and at the same time to hold an important skilled group in their respective communities. This is all the more interesting in light of recent criticism that institutions of higher learning are unwittingly robbing rural communities of their natural leaders by pointing them toward careers in urban areas.

facts and figures for a rehabilitation hospital

HERBERT W. PARK, M.D., HERBERT LUST
ALMA D. BROH-KAHN AND ROBERT W. BOYLE, M.D., Ph.D.

RESULTS OF REHABILITATION in the Armed Forces during World War II prompted the Veterans Administration to set up rehabilitation programs in most of its hospitals following the war. One of these hospitals, Fort Thomas, Ky., was designated as a pilot institution for the rehabilitation of veterans. Although all Veterans Administration hospitals have rehabilitation as a part of their program, the Fort Thomas hospital has rehabilitation as its major goal.

This experience indicates that there is merit in a rehabilitation program even when it is judged solely from the standpoint of cost.

Most cases referred to the institution are characterized by extreme chronicity and symptomatology otherwise unfavorable for rehabilitation in the average Veterans Administration hospital. The prime factor missing in these patients is motivation. Due to long illness and severe disability, many of them have given up hope of achieving any degree of their old independence. Some are persons who have never made any kind of satisfactory adjustment to their external environment.

Good rehabilitative measures begin in the acute stages of any disease. Good definitive care, with the vision of rehabilitation as the end point, is a necessity for satisfactory results. For the majority of patients at the Fort Thomas hospital, rehabilitation procedures were started during the definitive care of the patient. This is a common procedure in most modern hospitals. It consists of good physical medicine—early ambulation, physical therapy, occupational therapy, bedside speech therapy—and psychotherapy as soon as they are indicated.

Every physician views the immediate goal of his medical treatment as a return of the patient to community life. When the acute phase of a chronic illness befalls a patient, however, many physicians resort to immediate definitive measures only and leave the eventual care to the family or to institutions.

Table 1 indicates the type of cases that were transferred to the Fort Thomas Veterans Administration Hospital during the two and a half years covered by this report. Perusal of the table will convince one of the extreme chronicity of most of the patients.

The data are from hospital records for patients discharged from the hospital during the period of Sept. 2, 1947, to March 1, 1950. A social service report on post-hospital adjustment is included in the patient record.

The facilities provided at the Fort Thomas hospital are the same as those of any general medical and surgical Veterans Administration hospital in the United States. They were expanded in the occupational therapies to include educational therapy and manual arts therapy.

In addition to the rehabilitation patients, there are about 90 acute definitive patients from the Greater Cincinnati area and 35 to 50 convalescent patients. These patients are not included in this study but are entitled to and do receive any of the rehabilitative services that are indicated. The reverse is also true: All rehabilitation patients are entitled to and do receive laboratory, x-ray, medications, surgical and medical services as they are indicated for the best welfare of the patient. It is not uncommon for a rehabilitation patient to be transferred into the definitive section for surgical procedures.

The daily cost per patient was high when the hospital was opened because basic operational cost is relatively higher with a low patient load. This fact is taken into consideration in the calculation of all the costs reported in this paper, in the determination of cost to the taxpayer, or of money being saved by the patients out of the hospital.

The over-all cost of rehabilitation services is indicated in Table 2, which shows a typical cost per patient-day of the various therapies and services. The total cost of therapy, $2.85, is slightly higher than would appear at first glance because at any one time probably not over one-half to three-fourths of the total hospitalized patients were receiving any or all of the services.

Table 3 indicates the number of patients in the group studied that were prescribed into the various therapies.

All patients in the rehabilitation program are admitted to the hospital, but if rehabilitation were available as outpatient care through the Veterans Administration some could reside in the community.

Patients are scheduled for therapeutic activities throughout an eight-hour day, five days a week,

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1 Types of patients admitted for rehabilitation

Classification	Number
Surgical	**38**
Orthopedic	
Amputations	14
Fractures	10
Other	8
Miscellaneous	6
Medical	**42**
Arthritis	
Rheumatoid	12
Hypertropic	8
Atrophic	1
Cardiovascular	
Cardiac	6
Peripheral vascular	6
Miscellaneous	9
Neurological and psychiatric condition	**112**
Psychiatric and/or neurological condition with determined etiology	
Trauma	
Encephalopathies	6
Cord Transactions	11
Hemiplegias	8
Peripheral nerve injuries	2
Infection	
Neurosyphilis	4
Anterior polio	4
Encephalomyelitis	1
Polyneuritis	4
Intoxication	
Alcoholism, chronic with psychotic reaction hallucinated type	1
Alcoholism, chronic with non-psychotic reaction	1
Disturbances of circulation	
Hemiplegias	
Psychiatric conditions with undetermined etiology	
Psychotics in remission	16
Psychoneurotics	28
Character and behavior disorders	4
Other conditions with undetermined or heredity causes	
Parkinsonism, postencephalitic	1
Huntingtons chorea	1
Multiple sclerosis	13
Total	192

giving them a prescribed program comparable to that of a community job. Evenings and weekends are free, providing an opportunity to resume, gradually, planned or self-initiated community activities. Leave of absence is granted for therapeutic reasons and for purposes of home visiting and maintenance of personal circle relationships. Each patient gives himself personal care and in several instances, training in self-care has been part of rehabilitation.

The social service section of the hospital attempts to secure a follow-up report on each veteran discharged from the hospital, six and 12 months after discharge and annually thereafter. The questions asked concern the adjustment of the patient to his social environment, the state of his health, and how much he is contributing to his own economic support, that is, the extent to which he is working and the amount he is earning.

Where the social service report is incomplete, it has been necessary to approximate the amount earned by studying United States Department of Labor statistics on various types of work in the community to which the discharged veteran has returned.

If a former patient has worked steadily, made a good adjustment in his community, and not reentered a hospital for care of his disability, he is judged as having made a good post-hospital adjustment. If he has made a somewhat satisfactory adjustment to his environment and has worked or is putting forth some effort to work even though it is not steady, his is called a fair adjustment to post-hospital life. If he has not made satisfactory relationships in his social life and is making little or no effort to support himself, but still has not returned to the protection of a hospital or other institution, his is called a poor adjustment. Patients who are going to school or continuing their college work with satisfactory grades are judged as having made a good post-hospital adjustment.

The group reported here includes only those patients who were discharged with maximum hospital benefits. This term means that the patient has progressed physically and mentally to his highest expected plateau. Except in progressive diseases such as multiple sclerosis, the patient can be expected to maintain that level of physical and mental health and hold a job commensurate with his ability. In some cases this may be opportunity unlimited. In others it may amount to a menial bench job or sheltered workshop position with little opportunity for economic independence or security, yet sufficient to enable him to carry on without institutionalization.

There is a large group (nearly one-fourth of the patients) who might be considered our failures. These are patients who were transferred, as not suitable for rehabilitation, back to hospitals from which they came; those transferred to other hospitals for further definitive care (as those needing more surgery to improve their disability, or post-psychotics who had an exacerbation of their former psychosis); those who left the hospital against medical advice or without official discharge, and those who were discharged for disciplinary reasons.

Indicated below are the follow-up results observed in the 192 cases treated at the rehabilitation center and discharged as having attained maximum hospital benefits.

Results	Good	Fair	Poor	No report
Number of Patients	94	27	22	49
Percentage	49%	14%	11%	26%

When the 49 cases on whom no reports were obtained are projected on the same ratio as the 143 cases in which social service reports were obtained, the results are as follows:

Results	Good	Fair	Poor
Number of patients	126	36	30
Percentage	66%	19%	15%

Approximately 85 per cent of the patients are estimated to have made a fair to good post-hospital adjustment without requiring further medical attention for correction of their disability.

A distribution of cases according

2 Patient-day cost of rehabilitation services

Therapy	Cost per patient-day	Per cent of total patient-day cost*
Physical therapy	$ .61	5.14%
Exercise therapy	.29	2.44%
Occupational therapy**	.43	3.62%
Manual arts therapy	.72	6.07%
Educational therapy	.40	3.37%
Social service	.17	1.43%
Clinical psychology	.23	1.94%
Total	$2.85	24.01%

*Total hospital cost per patient-day: $11.87.
**Includes speech therapy.

3 Use of rehabilitation services

Treatment or service	Number of patients	Per cent of patients
Physical therapy	101	52%
Occupational therapy	126	66%
Exercise therapy	186	97%
Educational therapy	163	85%
Manual arts therapy	171	89%
Psychotherapy	62	32%
Speech therapy	6	3%

to length of hospitalization and end results is shown in the table below. This table indicates that about 56 per cent of the cases were treated adequately—with good post-hospital adjustment—in a period of hospitalization of less than six months.

Number of days treated	Good	Fair	Poor	Total
0-90	20	7	9	36
91-180	50	11	10	71
181-270	29	5	6	40
271-360	18	6	3	27
361 and over	9	7	2	18
Total	126	36	30	192

The relationship of end results and age, shown in Table 4, reveals some evidence that the prognosis in rehabilitation is not affected greatly by the patient's age. Since this group of patients is not of sufficient size, no definite conclusions can be drawn.

In order to calculate the cost of hospitalization and the amount saved by discharging the patient from the hospital, it was necessary to determine each cost individually because of progressive changes that occurred in the per diem cost.

It must be remembered in calculating per diem cost in a government institution that this cost includes the salaries of all the doctors, nurses, attendants and other ancillary professional, nonprofessional and administrative personnel. This is not true in all private, semiprivate or charity hospitals where the doctor's fees are paid by the patient or the doctor's services are gratuitous. The averages of the various end result groups are reported in Table 5.

Rehabilitative effort was unsuccessful for approximately one-third of all patients when we place in this category those who made a poor post-hospital adjustment in addition to those who were not rehabilitated at the time of discharge. However, if two-thirds of all the disabled persons in this country were to be rehabilitated, the economic results would be praiseworthy. Benefits would accrue not only to the disabled individual, but also to the country as a whole. The disabled would be removed from community welfare rolls to participate in remunerative activities.

If administrators of state, county, city and private hospitals could study the disabled persons in their communities and carefully select those who were medically and psychologically suited for rehabilitation, the chances of getting good post-hospital adjustment would be increased greatly over the figures listed here.

In a program of this sort, the concept of rehabilitation should include the teaching of self-care. If chronic, bedridden patients can be taught to care for themselves, the man-hours of work by nurses and attendants is thereby reduced. If they can go home and care for themselves, a member of the family or a caretaker may be released for a more productive life.

Many patients in a rehabilitation program can be cared for in an outpatient or clinic service without using needed hospital beds. This type of patient is handled effectively by the New York Rehabilitation Center, the Institute for Crippled and Disabled in New York, and by the Mayo Clinic. Many of the newer departments starting throughout the country are begun on this basis until a profitable program is established.

Our experience at Fort Thomas leads us to believe that we can offer the following suggestions for an outpatient rehabilitation plan.

- Pre-admission study and evaluation of each patient by the rehabilitation staff is of paramount importance. Staff meetings devoted to discussion of the response of patients to their treatment should be held regularly.
- Full use of existing community services could make possible a broad program of rehabilitative activities. Of particular value are academic and vocational schools, visiting teachers and nurses, vocational and psychological testing and counseling services, employment services, speech and hearing clinics, public and private welfare and relief organizations, organized recreational and leisure time activity programs, voluntary social welfare groups of many kinds, and public and private transportation facilities.
- In using community resources, controlled and financed by different agencies, the care of the patient must be planned. There must be a coordinator for all the services to be used so that (1) the patient does not become confused; (2) the equipment is adequate for his program, and (3) sufficient, trained staff is available to care for the patient's needs.
- Active participation of the patient is important to the success of rehabilitative measures and should be a basic consideration in terms of both the potentialities and limitations of a rehabilitation program.

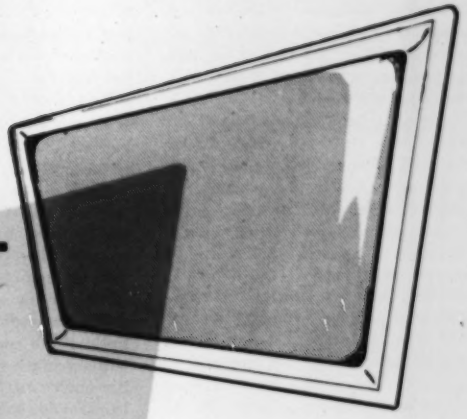
4 Age as related to post-hospital adjustment

Age distribution	Good Number	Good Percent	Fair Number	Fair Percent	Poor Number	Poor Percent	Total
20-25	40	73%	9	16%	6	11%	55
26-30	31	70%	8	18%	5	12%	44
31-40	32	60%	9	17%	12	23%	53
41-50	14	60%	4	17%	5	23%	23
51-60	7	46%	6	40%	2	14%	15
61 and older	2	100%	0	—	0	—	2
Total	126		36		30		192

5 Average cost per patient and average amount saved by discharge

Number of patients	End Results	Average days hospitalized	Average total cost per patient	Average days discharged	Average amt. saved patient by discharge	Average amt. earned since discharge
94	Good	193	$4,742	385	$6,529	$1,660
27	Fair	257	6,337	381	6,538	371
22	Poor	168	4,398	421	7,490	278
49	No report	168	3,200	238	3,487	—

a combination television-radio system for patients



JAY W. COLLINS

IN THE NEXT few years most hospitals will be faced with the problem of "What should we do about television?" The ever-changing—but never decreasing—problems of the hospital administrator are thus augmented by a rather complex and controversial addition.

In the midst of the final stages of constructing a completely new hospital, we could not delay our decision on the future of television in our hospital. Significant economy naturally results from installing electrical wiring during the building phase rather than after the building is complete and in operation. Accordingly, we made such investigation as we could to determine the feasibility of this innovation.

For more than one year we made television available to the patients in our present hospital. By arrangement with a local television company, sets were provided those patients who expressed a desire for the service. Certain safeguards had to be observed, however, for the protection of the patients.

Those with medical conditions for which any excitement would be detrimental were not supplied with the service after consultation with their physicians. There also were other medical circumstances precluding the use of this entertainment device.

Patients in multiple-bed accommodations constitute another administrative and medical problem. Often one of the guests in a two or four-bed room is seriously ill or for some other reason should not be exposed to the sight or sound of video diversion. The presence of an oxygen tent has also been determined as a reason for not having a television set in the same room.

Standard television sets were not found practical for patient use. In the first place they are not built high enough so that a recumbent patient can view them with any comfort. Then there is the problem of changing the controls, and the

Mr. Collins is executive director of the Glenville Hospital, Cleveland, and will head the new Euclid-Glenville Hospital which is to be completed this month in Euclid, a suburb of Cleveland.

very real problem of controlling sound. An antenna necessary to receive the TV signal had to be considered, as did protection from electrical interference.

Our solution, during this trial period, was to place a table model set on a specially constructed high stand, and this stand on casters. To make it possible for the patient to change channels and adjust the set, and to encourage a low volume of sound, we used a push-button model which was put on the bedside within the patient's reach. This necessitated using a small seven-inch screen for good visibility.

The antenna was a problem we never solved. We used the "rabbit-ears" type which sits atop the set and is not only unsightly but bothersome to nurses and visitors. Interference from x-ray often affected TV reception.

Despite its popularity with our patients, the TV experiment was not a complete success. But it was also apparent that most of its shortcomings could be corrected with a correctly designed technical system.

We are now installing in our new plant what we believe is the first combination television and radio system to be piped to every bed. It avoids the failures of experimental systems, and has many unique features which enhance its effectiveness.

The basic unit of this system is the antenna, which will receive all local stations. It is unlike a home antenna in that it actually consists of a separate antenna to receive each telecasting station, and a section of it is specially tuned to the direction and wave length of each of the several local telecasting channels. The usual home antenna is necessarily a compromise mechanism, and would be very inadequate for an extensive and qualitative special system. These separate antennae will be mounted on a single mast atop our elevator penthouse.

Signals received on each of these antennae will run on separate cables into a central distribution amplifier and "mixer" where not only are the signals intensified, but the images are superimposed one upon another. All signals (or pictures) are then distributed to each bed in the hospital by means of a single small coaxial cable. The wiring for the radio system is placed in the same conduit.

In the wall at the head of each bed we have inserted a basic control box. From it the picture is delivered to the television set at the bedside and the sound is sent to the patient by the under-pillow speaker. The patient will not only hear the television by means of this under-pillow speaker, but also can select his radio channel by simply pulling the cord, which automatically changes stations. He will have his choice of five local radio stations, and each will be received on FM (frequency modulation) broadcast to prevent static.

The single under-pillow speaker which brings the patient the sound of either television or radio solves an important noise complication in multiple-bed rooms. The presence of a television set in a semiprivate room, for example, will not bother the non-interested or very ill patient if the set is placed so that he cannot see the picture, or if a cubicle curtain is used as a shield, for he will hear no sound at all.

Our patients will see the television picture on a specially designed set which will be placed near the patient. These sets will be consolette models on casters, with a medium-sized picture tube and screen. They will have the screen mounted about four feet from the floor for ease of viewing by a prone bed patient.

Maintenance of television equipment can be costly and time consuming, and we were determined to minimize these factors. This has been done by having sets which consist of replaceable sections. Any set will be put in working order in a few minutes by the simple expedient of plugging in a new section to replace the non-functioning unit. There will be seven plug-in sections, one each for picture, sound, amplification, power, and so forth. Using this technique we will not find it necessary to have many spare sets on hand, but rather will have a supply of replacement plug-in units. The defective units will be repaired by a commercial repair company on a contract basis.

Minimum maintenance is also provided for in the radio-television under-pillow speaker. Rubber enclosed, it was found to be in proper working order after beating it on the floor several times, and then throwing it from a third-story window onto a concrete sidewalk.

The combination television and radio system was engineered for us by a firm which specializes in hospital electronic systems. We have arranged to finance its cost on a pay-as-you-go basis, and after a few years shall have sole ownership. Nominal charges to patients using the system will provide the necessary income for payment.

We are well aware that making this service available to patients creates many new problems—just as does any other new service. Judgment must be used in determining which patients may have their television plugged in, but we have found that there are techniques for easily deciding on that as has been done for radio and telephone service in the past.

Also, there is a limit to the amount of furniture that can be put in a patient room and still not hamper professional personnel in their duties of treating the patient. Some attention must also be given to the content of the programs which will be seen or heard by patients with varying types of illnesses. We have devised systems to minimize these and other attendant problems.

We have accepted as a basic tenet in every phase of planning the Euclid-Glenville Hospital that we want to minimize its institutional character and make it as homelike as possible. A vast majority of the people in our community view television in their homes, and we feel that there is a definite therapeutic value in giving the same entertainment and relaxation to these same people when they are in our hospital.

Our trial period has proved to us that a sizeable portion of the public wants television service, and that it has more benefits to the patients than it has drawbacks in our operation. We are confident that a combination system, engineered as described here to overcome the majority of its inherent problems, is a worthwhile investment in patient service.

The Princeton Hospital Master Plan includes three phases of construction: a new nurses' home, hospital expansion and a medical arts building. Phase one, the nurses' home, has been completed, and is discussed in this article

A new nurses' home for Princeton Hospital

J. W. KAUFFMAN

PRINCETON (N.J.) HOSPITAL is being developed from a small community hospital of 90 beds and 18 bassinets to a modern community center.

The hospital is situated halfway between New York and Philadelphia. The industry of the community is made up of Princeton University, other educational institutions and research and testing projects. The community has grown rapidly in the last 10 years, and it is predicted that another 10,000 persons will be living in the area within the next five to seven years. The hospital now serves a population of some 30,000 people.

The Princeton Hospital master plan is the result of eight years of planning. In 1941 the late Dr. Claude Munger completed his first survey. In 1946 be broadened the 1941 survey, and with the hospital building committee and the architectural firm of York and Sawyer, the first two phases of the development were brought to the preliminary drawing stage.

To continue operation of the hospital at the time construction was being carried on necessitated the development of the master plan in three phases: (1) a new nurses' home; (2) expanded hospital beds, service facilities and diagnostic facilities; (3) a medical arts building in which public health groups also could be housed when the need arose.

Preliminary estimates of the cost of phases one and two were $1,500,000. After many formulas were explored, it was decided by the board of trustees that a general fund-raising campaign should be undertaken for $1,200,000. In 1948 fund raisers were engaged. The first campaign fell short of its goal. A second attempt was made, and in 1949 the building fund went over the top.

Application was made to the New Jersey State Department of Institutions and Agencies for Hill-Burton funds. The Princeton area had a high priority and was awarded $386,000 toward phase two.

In each phase of development of the master plan, the persons who would eventually use the facilities were given ample opportunity to review, make suggestions and criticize. The preliminary plans were reviewed many times by all concerned before the working drawings were finally developed. It was also the administrator's practice to obtain the written approval of the final plans by department heads, doctors and personnel concerned. This insures forethought and final satisfaction.

Even though additional beds were critically needed, phase one —the construction of the new nurses' home—had to be the first

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project. This was necessary because the old nurses' home was in the way of hospital expansion. It is called the "old" nurses' home because the building was a historical landmark before it became the first hospital in 1919. In 1929 when the present hospital was completed, this building was converted to the nurses' home and housed 24 persons in exceptionally poor quarters.

Some may question why a nurses' home was built when many metropolitan area hospitals were discontinuing their nurses' homes and the housing of personnel. As far back as 1931 housing has been critical in the Princeton area. The demand for rooms and apartments far exceeds the available space, and unfortunately there is no forseeable relief of this situation. Therefore, if Princeton Hospital was to obtain nurses, it would have to provide living accommodations. The hospital has not and does not contemplate conducting a nurses' training school.

"Lambert House," as the nurses' home has been named officially, is a living memorial to Gerard B. Lambert, Jr., who was the son of Gerard B. Lambert, the principal donor of the building. Mr. Lambert requested that from the street the building appear as a separate unit. It was the desire of the administration that the building be connected with the main hospital. The architects achieved this easily because of ground contours. From the street the building looks like a three story structure standing alone. From the hospital property, however, it can be seen that Lambert House is a four story structure, and all north room windows on the ground floor are above ground level.

The ground floor is entirely hospital expansion and consists of a new dishwashing area, which is large enough to service the expanded hospital; a cafeteria, which is used by all personnel and doctors; a small dining room for meetings; rest rooms; a women's auxiliary library for patients; a meeting room seating 50; a nurses' recreation room; bulk storage; a flake ice machine room.

The cafeteria is an all electric unit with a grill, refrigerator, ice cream cabinet and conventional cafeteria equipment. The cafeteria does not have an institutional appearance. This is accomplished by a center wall which shields the view of the cafeteria counter from the dining area, generous provisions of tray stands so that dishes are removed from the tray and placed on the table, use of linen tablecloths and a cafeteria worker who clears soiled dishes from the tables.

The administrator had the opportunity during the war years to wash dishes and pots and pans during help shortages, and it was his opinion that special thought and planning should be given to these areas. The dishwashing room has a large receiving window where trucks from central tray service are unloaded. Dishes from the cafeteria flow over the same counter. The scraping section is located at this window. Dishes move to the left and glasses to the right. Dishes are racked and passed over a prerinse sink and then into a new double tank dishwashing machine with a final high temperature rinse. Glasses are run through a glass-washing machine where they are brushed, racked, washed and sterilized. After both machines, there is ample table space for air drying and racking. A silver washer is also being installed.

The women's auxiliary library has floor-to-ceiling shelving. Books are circulated to the patients by book carts.

The meeting room is used by the women's auxiliary, medical staff, nursing and for all other departmental conferences. The room's equipment consists of folding chairs with padded seats and backs, a wall-mounted projection screen, blackboard, x-ray view boxes, slide projector and movie projector.

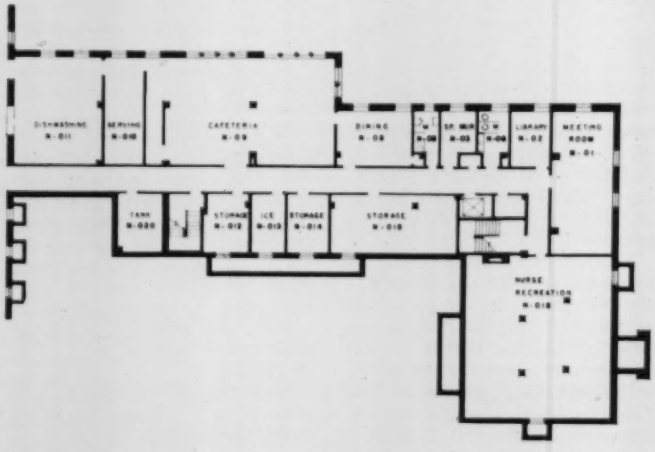
The nurses' recreation room is not finished, but it will contain a ping pong table, other games and recreation equipment.

The flake ice machine room is centrally located and serves the entire hospital. Ice is delivered and stored on patient floors and in the kitchen in stainless steel insulated carts.

As the plans for Lambert House developed, it was decided that each nurse should have her own room and that the over-all accommodations should have a homelike atmosphere. The advantages available would have to equal those that a nurse would have in her own apartment off the premises.

It was estimated that facilities would be required for 50 nurses. The architects were requested to design the building so that it easily could be expanded in the future. This was accomplished by an L-shaped structure, which future development will convert to a T.

The building has 51 private bedrooms, each with a lavatory and closet. The rooms are approximately 10 by 14 feet. Each floor has a private living room with either a television set or a radio-phonograph and a pullman kitchen shielded by a large venetian blind. The kitchen equipment consists of



THE ground floor is entirely hospital expansion and is connected with the main hospital.

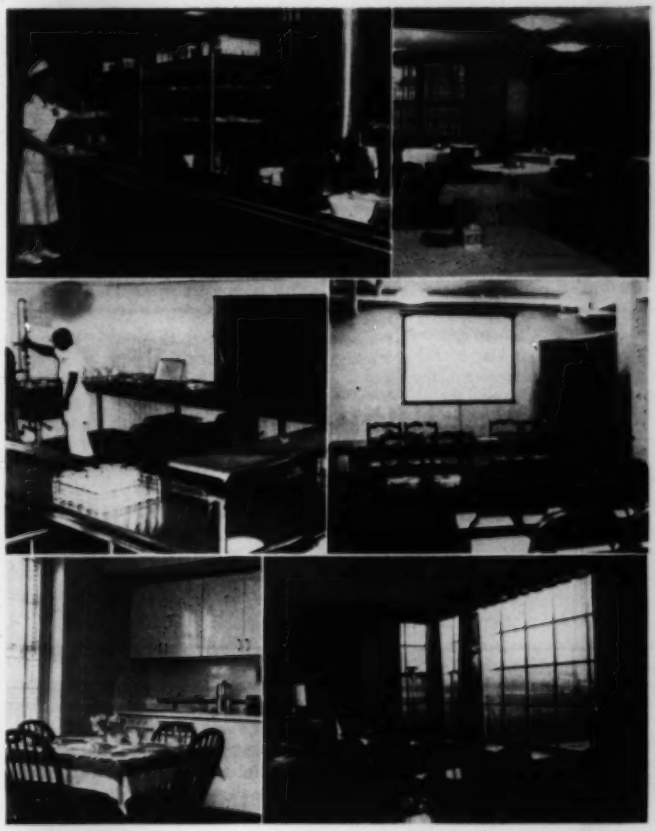
a three-plate electric stove, broiler, sink, storage cabinets and refrigerator. On each floor there is a laundry with an automatic washer, two ironing boards, drying racks and two stationary tubs. Centrally located on each floor there is a large bathroom with a tub and shower, two toilets, two lavatories and a stall shower. For service facilities, each floor has a janitor closet. The building is equipped with a linen chute and elevator. On the second and third floors there are seven rooms with connecting baths. These are assigned to supervisors and department heads.

For communication each bedroom has a message indicator and buzzer controlled by the hospital telephone operator. Phone calls can be taken or made from a telephone booth centrally located in the corridors. Supervisors' rooms have telephones connected to the hospital switchboard.

One of the unique features of comfort for the nurses was achieved by the installation of doors made of adjustable wood louvers, which permit circulation of air through the room and into the corridor where ducts carry the air to the exhaust fans located on the roof. Because of this, Lambert House is probably the most comfortable place in Princeton, especially in the summer.

Hospital policy required that the main living room be homelike and exceptionally attractive. The architects achieved beautiful results by designing this room off an entrance foyer. The living room is down two steps from the foyer level and has a fireplace and large colonial bay window overlooking a flagstone patio. There is a small reception room, office, rest room for men and telephone booth off the entrance foyer.

Believing that no two people could agree on color schemes, the decorating of all but the main living room was left to the administrator and architects. After exploring many decorating possibilities and considering future maintenance problems, three basic colors (pastels)—green, pink and yellow—were chosen. All rooms and corridors were painted alternately with one of these shades. Venetian blinds were chosen for all windows and picture frame furniture for all bedrooms. The main living room was decorated by a local interior decorating firm.



ABOVE, left: The cafeteria is an all electric unit with a grill, refrigerator, ice cream cabinet and conventional equipment. Above, right: The dining area is separated from the counter by a wall, and does not have an institutional appearance. Center, left: Dishwashing area. There is a dishwasher, glasswasher, ample space for drying and racking. A silver washer is also being installed. Center, right: The meeting room is used by the women's auxiliary, medical staff, nurses and for all other departmental conferences. Below, left: Each floor is equipped with a pullman kitchen shielded by a large venetian blind. Below, right: The main living room has a fireplace and large colonial bay window overlooking a flagstone patio.

The outside of the building is colonial red brick. The entrance porch is flagstone with wrought iron trellis and a sloped copper roof. There is a circulating hot water heating system operated by steam from the hospital power plant.

The building was constructed at a cost of $365,573 by a local construction company. The cost of the nurses' home section of this building was estimated at less than $300,000. The furnishings cost $19,000.

Construction of Lambert House began in October 1949, and the formal opening and occupancy took place in November 1950. Phases two and three, the hospital expansion and medical arts building, were placed under construction in April 1951. Phase two will be completed in 1952 and phase three during the first half of 1953.

Recently the occupants were requested to give an opinion of living conditions in Lambert House. The greatest compliment and satisfaction to the architects and building committee must have been the comment, "If the home was to be reconstructed tomorrow, no changes or improvements could be suggested."

Ways and means to ease the labor shortage

HELEN M. BRYAN, R.N.

TO FIND THE means by which we can provide our patients with adequate nursing care and combat the shortage of both professional and nonprofessional personnel is the problem foremost in our minds at present. This article, therefore, discusses some of the labor saving devices and short cuts which can be used in hospitals to help ease, perhaps, these situations.

In attempting to explain these devices, it is best to subdivide the discussion into three general headings: (1) How personnel may assist; (2) how methods of distribution of hospital equipment might be improved; and (3) how actual new equipment might be utilized.

Under the first heading we may consider the ward secretary. The ward secretary can relieve the head nurse of many clerical and other non-professional duties. (In the March 1952 issue of the AMERICAN JOURNAL OF NURSING, there is an article entitled, "Non-Nurse Managers for Hospital Divisions," which points out these duties.) The Youngstown Hospital Association, for example, conducted a survey and found that its ward secretaries saved the head nurse at least two to four hours of time per day by doing her non-professional duties.

Ward secretaries, also, can help the doctors. The secretary has a list of each doctor's patients and when he comes to the nurses station she hands him his charts. When he is ready to make his rounds, she contacts the nurse. The secretary, also, is responsible for all visitors and telephone calls that the patients receive. Another of her duties is to operate the two-way communication system. This saves time for the nurses, and also helps to satisfy the wants of the patients more quickly.

Secondly, we shall consider how methods of distribution of hospital equipment can be improved. One outstanding short cut is the direct stocking of the linen cupboards by the linen room. In some hospitals, it is necessary for the head nurses to make out a daily linen requisition which has to be in the office early in the morning and then sent to the linen room in time for the supply of linen to be distributed to the divisions. This consumes the head nurse's time just when she is needed most to check on the personnel and the care of the patients. When the linen room is responsible for the supply of linen, an order guide is posted on the door of each linen cupboard, and this gives the amount of linen usually needed on that particular division. Each morning maids from the linen room, following the guide, stock the linen cupboards. Linen packs consisting of a patient's gown, sheet, pillow case, bath towel, face towel and wash cloth are delivered to the division in the late afternoon and are placed in the patient's rooms early in the morning by the night auxiliary helper. This method requires less linen in circulation, the head nurse has more time to devote to her patients, and the divisions are adequately supplied with linen at all times.

This procedure, also, can be applied to store room supplies. In addition, drug supplies, such as narcotics, ampules and stock drugs could be stocked by pharmacy.

Another time saver is individual small boxes made of tin or plastic materials which are used to store medications in the medicine cabinets. They aid in distribution and also keep together all the medications for one patient. Further, there is less danger of the wrong medication being given, the nurse doesn't have to spend time sorting out the patients' drugs, and after the patient is discharged the drugs not used can be returned to the pharmacy.

Following along this same line, the maintenance department can help by having some one from that department regularly make the rounds of the hospital to check on "maintenance" repairs. In a Cleveland hospital, an electrician checks the electrical equipment, including lights, every day. He has a cart with supplies on it so that he can make all repairs as he goes around. This saves time both for his department and for nursing personnel, and is particularly important where the nurses carry a heavy assignment.

Central supply, also, can help with general distribution of equipment. Even the basic essentials for patient care, including all necessary bedside utensils, can be cleaned on the divisions and then sent to central supply where they are assembled in a pack, autoclaved, and returned to the bedside stands. The pack cover is made of a square piece of muslin and then tied. This pack includes a wash basin, soap dish, emesis basin and mouth wash cup. Bed pans and urinals make up a separate pack.

In discussing central supply, there is a third general topic—equipment. Central supply can be improved with some of the new devices, for instance a tying machine which can save time and cost by tying packages containing sterile supplies, such as gloves. This is easily operated, automatically adjusts itself to various size packages, and ties a neat non-slip knot by means of a lever.

Another time saver is the glove machine. The care of surgical gloves has always been a slow, monotonous procedure, but with a machine to dry and powder the

Miss Bryan is director of nursing service for the Youngstown (Ohio) Hospital Association.

gloves, this task is speeded up. The gloves are placed inside the machine in an aluminum cylinder which will wash and dry up to 100 gloves in 30 minutes. When dry, the gloves are placed in the powdering cylinder in the machine where they are powdered both inside and outside in five minutes. The machine is simple to operate and is entirely controlled by a timer switch which shuts off all current when the gloves are ready to be placed in wrappers. The machine, also, is easily kept clean and occupies only 18 inches of space.

Still another time saving device is that which cleans hypodermic needles in about half the time it can be done by hand. It swabs out the needles with a power driven swab operated at about five revolutions per second. This machine may be used for all types of needles and is so easily operated that almost anyone can use it.

Sharpening needles has been another unpopular and time consuming assignment. Now, however, there is a mechanical needle sharpener which not only saves time, but greatly improves the condition of the needles as they are sharpened. Many needles are reclaimed that otherwise would be discarded. This machine is a little more difficult to operate, but after about a two-week training period any employee with average intelligence usually can make it work efficiently. At Youngstown (Ohio) Hospital such a machine has cut the cost of needles 18.5 per cent.

The method of supplying oxygen, also, has been improved. Piped-in oxygen and iceless oxygen tents which save both time and manpower, have been developed. These oxygen tents, also, are such that they give the nurses more area in which to care for the other patients in the room.

To continue with general equipment on the divisions, another convenience is the use of the bedside curtain in place of paneled screens. The patient has just as much privacy with a curtain as with a screen and there is less noise and energy exerted in operating a curtain. In some private rooms a draw curtain can be placed just inside the door.

To add to the improvement of the patient's individual unit, there is a bedside stand to which is attached a ring which will hold a bath basin. When this is used, the nurse does not have to remove the books, radios, flowers, or phones from the top of the stand. It is necessary, of course, to have the basins a size to fit in the ring.

In the obstetrical department may be found another time and energy saver. This is an infant crib which is so constructed that on the top level is the baby's bed, on the middle level is a shelf which slides out and may be used for supplies or where the baby may be placed while the bed is being made, and on the bottom level are two compartments built side by side. The one compartment can hold a day's supply of diapers and other linen, and in the other compartment can be stored such things as the baby's bath articles. By using these cribs instead of the old kind, everything is at hand for giving the baby complete care. These cribs also can be taken to the bedside of the mothers, thus saving the time and trouble of transferring the babies to a conveyor, then to the mothers.

Bottle warmers also are helpful in a nursery or pediatric department. These may be kept in a room set aside for this purpose and should be easily accessible to the nurses. Bottles, of course, should be kept at the same temperature all the time, even when they are being wheeled along the corridors to the babies. This is achieved by using the bottle warmers.

Considering obstetrics, it saves time to have the examining supplies always at hand in the labor rooms. This is accomplished in some hospitals by having the examining tray and all supplies assembled on these shelves. Not only does this save much time for the doctors, but these cupboards can be stocked by auxiliary personnel, thus giving the nurses more time to care for the patients.

In the operating room, a very useful device is a pressure instrument washer-sterilizer. This instrument sterilizes and dries two full trays or sets of instruments in about 20 minutes, and it can be used separately for rapid sterilization of clean instruments, or for washing and sterilizing of soiled instruments. The instruments may be placed in the trays in the same manner as they are placed in the regular sterilizers.

After going over all these items, we realize, of course, that it is not possible to discard all of our less modern or efficient equipment. But all hospital administrators, directors and department heads need to keep constantly informed on what new equipment is available, in order to insure adequate and improved patient care.

BY storing medications in individual boxes according to the patient's room and bed number, patients are assured correct prescriptions and nurses do not have to waste time sorting the drugs. After a patient is discharged, the drugs not used can be returned to pharmacy.

does medical practice affect hospital costs ?

KARL S. KLICKA, M.D.

Dr. Klicka is director, St. Barnabas Hospital, Minneapolis. This article is adapted from a paper presented at the Upper Mid-West Hospital Conference, St. Paul, May 14-16, 1952. Statistical information was obtained from Bulletin #7 titled "Medical Care Expenditures, Prices and Quantity 1930-1950," prepared by Frank G. Dickinson, Ph.D., director, Bureau of Medical Economic Research, American Medical Association.

MOST HOSPITAL ADMINISTRATORS would answer this question with a firm, "Yes"! But when it comes to expanding on the subject there is little that has been said beyond general statements, most of them to the effect that medical practice has increased hospital costs. This assumption was aptly phrased in a National Hospital Day article that appeared in the May 11, Sunday *Saginaw* (Mich.) *News*. One paragraph stated, "But the fundamental cause for increased hospital costs is improved hospital medicine, more detailed and more extensive diagnoses, the increased use of the laboratory for checking on treatments, more extensive use of the radiology department, and new developments in the use of still scarce and expensive drugs." The author of this news item was not in doubt about the effect of medical practice on hospital costs.

Physicians are keenly conscious of increasing costs but do not necessarily share the foregoing concept with hospital administrators. Editorials in many medical periodicals frequently refer to the fact that hospitals are receiving an increasing share of the medical care dollar whereas physicians are receiving a diminishing portion. Doctors usually feel that high hospital costs affect their income, and as a group they stand at the top of the list in grumbling about the high cost of hospital care. They feel rather frustrated about it too. An editorial in *New York Medicine* (February 20, 1952), titled, "The Cost of Medical Care," stated, "The physician has no control over hospital costs, naturally." The author of this editorial doubts that medical practice has a significant influence on hospital costs.

In gathering material for this article the general medical and hospital literature was read extensively but little has been written on the subject. Sources known to maintain excellent statistical departments were contacted. The responses were consistently the same, "We are sorry to advise you that we have not studied this aspect of hospital cost." Here is a field which as yet has not been explored. George Bugbee, executive director of the American Hospital Association, answered that he did not think much had been written on the effect of medical practice on the cost of hospital care. He said, "As a matter of fact, the Commission on Financing of Hospital Care is exploring this whole field and I hope they will cover it well."

The total cost of medical care to the consumer is constantly increasing. In 1950 it amounted roughly to $8.5 billion. Since 1930 the proportion of the medical care dollar going to physicians has steadily decreased whereas the amount going to hospitals has increased. In 10 years the percentage increase to hospitals has been 35.3 per cent. In the same span of time the proportion of the medical care dollar going to physicians has decreased 6.6 per cent. On the basis of price indexes, hospital rates appear to be running away from the other components of medical care.

The natural question that arises in the mind of a physician reviewing these facts is, "Why?—Why have hospital charges risen so much faster than the other elements that go into total medical care?" The doctor is naturally concerned because of its direct effect on him. He listens to patients complain about high hospital bills, and in some instances he must wait a little longer for his bill to be paid. Usually he blames this on the fact that it takes all of the patient's available funds to pay the hospital bill. This is an unfortunate situation, for patients naturally expect their doctors to know why hospital costs have risen. The doctor's sources of information do not answer this question. What is worse, however, the physician is left with the impression that hospital charges are much higher than they should be. A hospital administrator's first task is to explain to the physicians on his staff what has happened to increase hospital costs. When they understand, their patients' questions will be more intelligently answered.

It is of fundamental importance in interpreting the information presented here, to point out that these facts are based on a proportionate distribution of the total amount of money spent for medical care by consumers. It has nothing to do with the cost of the indi-

vidual illness. It does not reflect the cost of a hospital bill for an illness with the charge that the doctor makes for taking care of the patient while he is ill. The doctor and his patient are erroneously under this impression, however.

The explanation of the increased total amount spent for hospital care as related to that which is spent for over-all medical care is based on usage. Physicians today admit many more patients to hospitals than they did in 1940. In 1940 there were 6,254,850 admissions to voluntary hospitals. By 1950 this had increased to 11,253,902, approximately 80 per cent. During this same 10-year period the total population of the United States increased from 131,669,257 to 150,697,361, or only 15 per cent. This means that our population is using more hospital care today than it did 12 years ago and that the over-all total cost has increased out of proportion to the increase in cost of other items of medical care. Usage and service become apparent as a reason for the increased percentage consumption of the medical care dollar rather than higher operating costs alone. Hospitals thus have been falsely accused. Furthermore, it is somewhat ironical that hospitals, as they have extended themselves to provide greater service, have not been properly recognized for this effort.

The total expenditures for medical care in relation to the percentage of consumer expenditures for other commodities from 1930-1950 increased considerably but varied little in relation to the total amount spent by the consumers. Table 1 illustrates that in this period total medical care expenditures increased but 0.3 per cent. The hospital increase was 0.4 per cent, or 0.1 per cent greater than the total average. These data reflect personal consumer expenditures only; they do not include government expenditures. Actually the demand for medical care has always been small in comparison with other consumer items. It seems safe to say, however, that it has been small not because people have been unable to afford more but because they preferred to spend their budgets on other things. This is natural. No one likes to pay for something that is not wanted, and illness has never been a popular commodity.

Table 2 shows that expenditures for luxury items have continued at about the same level during the 1930-1950 period. Expenditures for these items have not been reduced because of higher medical costs.

The ability to pay, or relationship of the price of medical care to income, is an important factor in considering the cost of any commodity to the consumer. In relation to income, hospital rates are cheaper than they were in 1935-1939. As measured by the *Consumers' Index* of the United States Bureau of Labor Statistics, the average weekly earnings of production workers in manufacturing industries increased 165 per cent between 1935-1939 and 1950. During this same period hospital rates increased 135 per cent.

Inflation is the most important cause of increased hospital costs today. From 1940 to 1950 the purchasing power of the dollar decreased to 53 cents. The importance of this decline is tremendous as it relates to hospital costs. This is illustrated in Table 3.

In Table 3 the average total hospital charges per day for the member hospitals of the Minnesota Hospital Service Association have been listed for the years 1940 to 1951. The percentage increase through these years amounts to 184.4 per cent. When these average charges are adjusted to the declining purchasing power of the dollar the actual increase in the average charge per day is reduced to 50.8 per cent. If the purchasing power of the dollar had remained unchanged during the past decade the fact would remain that hospital care has increased in cost by approximately 50 per cent. Two factors are responsible for this: (1) the type of hospital service resulting from changes in medical practices, such as the increased use of diagnostic facilities, usage of new and costly pharmaceuticals, and the application of new therapeutic techniques in the over-all field of medicine and surgery; (2) the increased number of trained hospital employees necessary to perform the new services demanded by these changes in medical practices, and the general trend in hospitals to pay salaries to hospital employees on an equal or near equal basis to salaries paid to employees in comparable positions in

Table 1—Selected Consumer Expenditures as a Percentage of Total Consumer Expenditures, 1930-1950

Year	Medical care (per cent)					
	Total medical care	Physicians' services	Hospitals	Drugs and sundry	Dental services	All other medical care
1930	4.1	1.3	0.6	0.8	0.7	0.8
1935-39	4.2	1.3	0.7	0.9	0.5	0.8
1940	4.3	1.3	0.7	0.9	0.6	0.8
1945	4.2	1.1	0.8	0.9	0.5	0.9
1948	4.2	1.2	0.9	0.8	0.5	0.8
1949	4.4	1.3	1.0	0.8	0.5	0.9
1950	4.4	1.2	1.0	0.7	0.5	0.9

Bureau of Medical Economic Research

Table 2—Selected Consumer Expenditures as a Percentage of Total Consumer Expenditures, 1930-1950

Year	Alcoholic beverages (per cent)	Recreation (per cent)	Tobacco (per cent)	Personal care (per cent)	Jewelry (per cent)
1930	—	5.6	2.1	1.5	0.8
1935-39	5.0	5.0	2.6	1.4	0.5
1940	5.1	5.2	2.6	1.5	0.6
1945	6.3	5.1	2.4	1.7	1.1
1948	4.6	5.6	2.3	1.3	0.8
1949	4.4	5.7	2.4	1.2	0.8
1950	4.2	5.8	2.3	1.2	0.8

Bureau of Medical Economic Research

Table 3—Inflation—Its Affect on the Average Per Diem Hospital Charge

Year	Average total hospital charge per day*	Increase (per cent)	Purchasing power of the dollar†	Average total hospital charge per day adjusted to purchasing power of the dollar	Increase or decrease (per cent)
1940	7.23	—	1.00	7.23	0.0
1941	7.35	1.7	.95	6.98	— 3.5
1942	7.84	8.4	.86	6.74	— 6.8
1943	8.16	12.9	.81	6.61	— 8.6
1944	8.67	19.9	.80	6.94	— 4.0
1945	9.09	25.7	.78	7.09	— 1.9
1946	10.35	43.2	.72	7.45	+ 3.0
1947	12.59	74.1	.63	7.93	+ 9.7
1948	15.41	113.1	.58	8.94	+23.6
1949	16.88	133.5	.59	9.96	+37.8
1950	18.02	149.2	.58	10.45	+44.5
1951	20.56	184.4	.53	10.90	+50.8

*Minnesota Hospital Service Association
†Consumer Price Index—Bureau of Labor Statistics

Table 4—Cost Per Illness Adjusted to Inflationary Effects

Year	Purchasing power of the dollar	Average total charge* per day adjusted to purchasing power	Increase (per cent)	Average length of stay	Average cost per illness	Increase or decrease (per cent)
1940	1.00	7.23	—	7.1	51.33	—
1941	.95	6.98	— 3.5	7.1	49.56	— 3.4
1942	.86	6.74	— 6.8	6.9	46.51	— 9.4
1943	.81	6.61	— 8.6	7.1	46.94	— 8.6
1944	.80	6.94	— 4.0	6.8	47.19	— 8.1
1945	.78	7.09	— 1.9	6.7	47.50	— 7.5
1946	.72	7.45	+ 3.0	6.7	49.92	— 2.8
1947	.63	7.93	+ 9.7	6.1	48.37	— 5.8
1948	.58	8.94	+23.6	6.0	53.64	+ 4.5
1949	.59	9.96	+37.8	5.6	55.78	+ 8.7
1950	.58	10.45	+44.5	5.5	57.48	+12.0
1951	.53	10.90	+50.8	5.4	58.86	+14.7

*Minnesota Hospital Service

industry and commercial enterprises.

It must be admitted that medical practice has definitely contributed to the increased cost of hospital care, but the effect of this has been particularly noticeable on the "cost per day." The important fact is that medical practice has been largely responsible for maintaining the "cost per illness" at a level which is only slightly above the level of 1940. Table 4 illustrates the effect of the decrease in the average length of stay on the average cost of illness when applied to the charge per day adjusted to the purchasing power of the dollar. The over-all increase in the cost per illness since 1940 is only 14.7 per cent. Medical practice has to a considerable extent offset the increasing cost of hospital care by reducing the length of stay of patients in the hospital. Some will say that this has been due in part to the pressure of overcrowding in hospitals, and to a certain degree this is true. Early ambulation would have developed as a trend in medical practice without this pressure, however.

"Charges per day" rather than "costs per day" have been used in these tables only because cost figures were not available. It seems safe, however, to assume that the trend would have been approximately the same if per diem costs had been used, for costs and charges follow one another closely. It also is assumed that the general pattern demonstrated here in Minnesota would be found throughout the country.

Increased medical costs are due to several factors. Doctors have improved their techniques and methods of handling illnesses. They have used diagnostic facilities increasingly to assist in diagnoses. These have been accompanied by the use of new potent pharmaceuticals. The combination has resulted in an age of medical miracles which in just 20 years has added almost nine years to life expectancy—from 59.5 years in 1930 to 68 years in 1951.

That the term "increased use of diagnostic facilities" is not loosely used is emphasized by the following statistics obtained from a 200 bed hospital for the 11-year period 1940-1951.

	1940	1951	Per cent of increase
Admissions	5,358	12,691	136.9
Hospital days (newborn omitted)	36,777	59,662	62.2
Pathology laboratory examinations	23,967	99,559	315.4
X-ray examinations	3,111	10,556	239.3

These figures are significant because they come from a hospital that did not vary its bed complement during the 1940-1951 period. During this same interval the staff changed only as would be expected with new younger practitioners gradually replacing the old. Nothing unusual occurred, however, to account for the dramatic changes in the foregoing categories except the practice of medicine itself. This is an interesting and informative reflection of a small part of what is called the changing practice of medicine.

These facts, then, present the important influences of medical practice on hospital costs. There is no question that medical practice has increased daily costs. Through greater utilization of hospital services the total nationwide cost of hospital care has increased and has proportionately risen higher than the cost of physicians' services. Greater per day cost plus greater usage has significantly raised the total cost to the public. After a careful analysis of all factors, however, the true fact emerges that the cost of illness today is little more than it was in 1940.

Paradoxically, medical practice is responsible in large measure for increased costs, yet must be given full credit for the fact that the total increased cost of an individual illness is as small as it is. The money that the wage earner saves as a result of his quick return to employment offsets the small increase in the cost of his illness.

HOSPITALS
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Post-Anesthesia—Post-Surgery

RECOVERY ROOM SERVICES

–A GUIDE FOR PLANNING

MARGARET K. SCHAFER, Nurse Consultant

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FEDERAL SECURITY AGENCY
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MANY HOSPITALS in recent years have recognized the need for post-anesthesia and post-surgery recovery facilities. This is a need related both to improving care for these patients and to economy in giving the intensive care required.

Many hospitals have gone forward with planning and establishing such units. This new development has pointed up the need for a guide which would synthesize the best thinking to assist hospitals planning to establish such units and to be used as a check list of current practices for units already in operation.

The planning guide published in these pages represents a very detailed field analysis by the staff of the Public Health Service. As a result of this field work and research, much information is now available for the first time in the form of a usable guide.

This publication has been reviewed and approved by the American Hospital Association and the National Committee for the Improvement of Nursing Services. The guide is a genuine contribution to better planning for better patient care.—GEORGE BUGBEE, Executive Director, American Hospital Association.

THERE ARE SO MANY difficulties in the way of advancing better patient care that hospital people sometimes become discouraged in their pursuit of that goal. They are more than gratified when some aspect of patient care can be improved in the same gesture which also makes better use of scarce personnel and expensive equipment.

The post-anesthesia—post-surgery recovery room appears to be just such a development. The experience of the handful of hospitals which pioneered this facility only a few years ago has been such that many more hospitals are attempting to follow their lead. Their inquiries have indicated the need for a comprehensive guide for planning and using the recovery room. Hence this paper, which represents a work of many months by many people most interested in and most experienced with the recovery room function.—LEONARD A. SCHEELE, M.D., Surgeon General, U. S. Public Health Service.

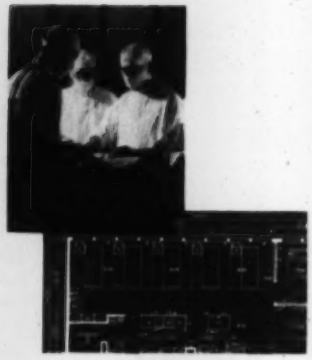
THE PROVISION of intensive nursing for patients during the critical hours immediately following anesthesia and surgery presents a special problem in nursing service administration. When professional nurse power is in short supply, the problem is more acute. The establishment of a post-anesthesia—post-surgery recovery unit offers a practical solution.

When patients needing a similar type of care are assembled in one area close to equipment and personnel, care can be managed with greater safety, economy and ease. One nurse can keep close observation over several patients if they are always in sight. Necessary treatment can be given by fewer nurses if steps can be saved and equipment is always at hand in the unit where it is to be used. Emergencies can be handled more speedily. Doctors can visit with less touring of the whole hospital. Patients and families cannot help but feel greater confidence and assurance that all is under control when such special care is provided.

Some of the values to be weighed by hospital and nursing service administrators speak for themselves: Emergency equipment on hand close to operating rooms; more efficient utilization of personnel and of equipment; post-anesthesia patients housed away from the usual traffic on the floors; and the psychological values to post-surgical patients, to other patients and to their respective families. Miss Schafer's manual explains in detail how to plan, equip and organize such a recovery unit.—MARION W. SHEEHAN, Director of Programs, National Committee for the Improvement of Nursing Services.

Post-Anesthesia—Post-Surgery

Recovery room services —a guide for planning



MARGARET K. SCHAFER AND T. P. GALBRAITH

GOOD CARE AND management of patients during the immediate post-operative and post-anesthesia period lessen surgical mortality and morbidity. Many hospitals find they can provide this care better in a special unit, staffed and equipped to meet the particular needs of these patients.

Extensive and formidable operations now being performed have increased the need for more skilled and detailed post-operative care by both physicians and nurses, but every surgical patient requires careful attention for some time immediately following his operation.

The immediate post-operative and post-anesthesia period is used here to designate that period of time following a surgical operation or anesthetic when the patient's vital signs, such as respiration, blood pressure and temperature are unstable, or he is reacting from anesthesia.

There are advantages in providing recovery room service in any hospital but especially in hospitals of more than 100 beds, because of the dispersion of surgical patients in these hospitals, and the number and complexity of surgical operations performed.

Advantages of a recovery room service: 1. Mortality and morbidity of surgical patients are decreased because conditions such as hypotension, hypoxemia, obstructed air way, shock, and hemorrhage can be prevented or instantly treated since all necessary equipment and supplies are readily available and a sufficient number of qualified personnel are present at all times.

2. Improved nursing care with medical supervision required by patients during the period immediately following a surgical operation is assured with a minimum of risk and loss of time.

3. The number of experienced nurses and the amount of special equipment needed are less, when patients receiving the same kind of care and requiring special treatments are concentrated in one area, than would be required to give comparable care to these same patients if they were scattered over a wide area of the hospital, and they are more efficiently utilized.

4. Post-operative accidents during transit from the operating room to a unit a great distance away are avoided.

5. Some of the confusion on the nursing units is eliminated and all patients receive better care at all times, because nursing personnel on these units are not interrupted from regular duties to give concentrated care to the immediate post-operative patient.

6. Relatives, friends of patients and other patients are relieved of the distressing, disturbing and annoying sights and sounds sometimes associated with patients recovering from anesthesia when such patients are not seen in corridors, elevators, semiprivate rooms or wards.

7. The morale of patients and relatives is strengthened, since they are assured that during this critical period the patient is under the constant vigilance of competent nurses, with all the necessary equipment and supplies at hand, and that the surgeon and anesthesiologist are nearby when needed to give close supervision and care.

8. Special studies and research can be better controlled.

PLANNING

The recovery room service should be planned jointly by all persons responsible for the immediate post-operative care of surgical patients or the provision of equipment, supplies, and services needed to assure this care.

These are:

1. The chief surgeon or chiefs of various surgical services and the anesthesiologist, who determine the post-operative care required or intended for their patients, and formulate policies and establish practices for the care of the patients, including routine orders and records.

2. The hospital administrator, who is responsible for the administrative planning and directs and coordinates the functions of all departments of the hospital.

3. The director of nursing service, surgical supervisor, operating room supervisor, the recovery room nurse, who determine and plan with the medical staff the nursing care, and the equipment, supplies and personnel required.

4. The director of stores, pharmacist, laundry manager, central supply supervisor, and clinical laboratory director, who advise on the planning of supplies and equipment and the procedures to be used in procuring and managing supplies and equipment.

5. The maintenance director, chief engineer, and housekeeper to

advise on the planning of the physical facilities and service aspects of the unit, since they should be responsible for the maintenance of the unit and equipment.

There are many important details for the clinical administrative staff to consider and develop before the recovery room is ready for patients. To assure coverage of these aspects a written policy and procedure book is essential. Consideration should be given to the following:

1. The criteria for admission of patients, and their length of stay in the recovery room.
2. The authority and policies for release or transfer of patients.
3. The care and treatments to be given all patients, and the special care and treatments anticipated for certain patients.
4. Staffing policies.
5. The procedure for obtaining and recording physicians' orders.
6. The reports and records to be kept.
7. The charges to be made, if any, for services, special medications and supplies.
8. Persons allowed in unit, including visitor policies.
9. Procedures for summoning physicians, nurses, or other personnel required for emergencies.
10. Procedures for obtaining supplies and equipment, including pharmacy, central supply, laboratory, and blood bank.
11. The maintenance and repair of equipment, and the housekeeping and maintenance aspects of the unit.
12. Safety measures necessary to prevent accidents when caring for unconscious patients.
13. Safety precautions required in oxygen therapy units as recommended by the National Fire Protection Association in NFPA Publication No. 565.

MANAGEMENT AND STAFFING

The proper management of a recovery room and satisfactory patient care depend on cooperative working relationships between the members of the surgical, anesthesiology and nursing services. The general planning of the types and manner of giving patient care and the staffing of the unit should be resolved at conferences attended by representatives of the three services who are familiar with all aspects of the objectives of the recovery room. The policies concerned with supervision and patient care are determined at these conferences. The over-all medical supervision and management of the unit is determined by the medical staff. It is considered best to assign the responsibility for the over-all medical coordination and supervision of the unit to one qualified physician. Where an anesthesiologist is a member of the hospital staff he is often given this responsibility. The surgeon's and anesthesiologist's responsibilities should be clearly defined. This is essential for nursing personnel assigned to the unit to avoid confusion in reporting patient's condition and obtaining necessary orders. A physician or resident physician should be available on call at all times.

Admission of patients: Criteria for selection of patients to be sent to the recovery room are, for example, the type and extent of the surgical operation and anesthetic, the post-operative condition of the patient, the need for careful watching and frequency of treatments and procedures, including blood pressure readings, oxygen therapy, intravenous fluids and blood transfusion. No fixed rule will govern all surgical patients. The need for care in the recovery room must be individually determined for each patient. A patient who received a general anesthetic for a relatively minor operation but who is unconscious and needs watching until he reacts fully may be ordered to the recovery room by the anesthesiologist. The surgeon may order to the recovery room a patient who received a local or spinal anesthetic or who has reacted from the general anesthetic but still requires careful watching and frequent treatments for his surgical condition. Also a patient who requires intensive nursing care for his surgical condition plus post-anesthetic observation and care may be ordered to the recovery room by the surgeon or both the surgeon and the anesthesiologist. Generally, it is a joint decision of all disciplines. A good plan is to have the operating room nurse notify the recovery room nurse by telephone of the approximate time of the patient's arrival, indicating the need for special care and equipment. The orders for treatments, medication, and other post-operative care are written by the physician in the operating room and attached to the clinical chart before the patient leaves the operating room. In many instances it is advisable for a physician to accompany the patient to the recovery room and write the necessary orders, inform the nurses of the care and treatments required, and administer to the patient requiring medical attention.

In some hospitals patients are placed in their own beds in the operating room and moved to the recovery room and subsequently to the nursing unit. This means the patient is lifted only once, at a time when there is sufficient help present. This one movement minimizes the possibility of circulatory disturbances and other injuries that may result when moving a helpless patient. When this practice is followed, the need for additional beds for the recovery room is eliminated, for patients are either taken to the operating room in bed, or their beds, with necessary attachments, are sent to the operating room. When beds are not interchangeable or hospital construction makes the movement of beds between units impossible, patients are transferred by stretcher to special adjustable beds or special stretchers in the recovery room, or the recovery room stretchers are sent to the operating room to receive the patients.

Visitors: Visitors are usually not permitted in a recovery room. A waiting room where relatives or friends can be comfortable and kept informed of patient's location and progress should be available. The purpose and use of the recovery room should be explained to the patient and his family before surgery to avoid unnecessary concern over the long absence of the patient from the nursing unit. When there is a separate section in the recovery room for dangerously ill patients, their relatives and clergy may be admitted in unusual circumstances without interfering with operation of the entire unit.

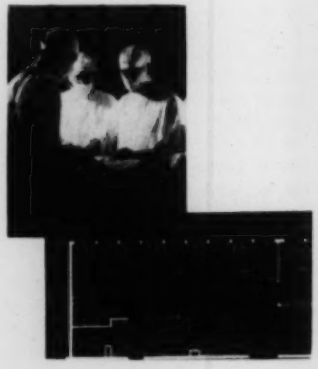
Charges: The policy of special charges for recovery room service varies in different hospitals. Usually no separate charge, except for special drugs and oxygen, is made for the recovery room service of short duration. The cost of operating the unit is then allocated to the various surgical inpatient units where the patients are assigned, since these units would otherwise be required to furnish the service if the separate recovery room service was not available. Some hospitals make a charge on the basis of time spent in the unit, or on the basis of a "group nursing" fee.

Records: The record prepared for each patient while in the recovery room should include the physician's orders, respiration, pulse and blood pressure readings, treatments and medications given, and the patient's condition on admission and discharge. These records are usually kept clipped to the foot of the bed where they are easily visible and readily available. A special recovery room record form may be used but many hospitals prefer to keep special forms at a minimum and use the same clinical record forms as used on other hospital units. When research studies are conducted, special study forms may be required, sometimes in duplicate, with one copy included in the patient's record and the other copy kept on file in the recovery room.

Transfer of Patients: The length of stay in the recovery room is dependent upon the patient's condition and the need for detailed care and treatments. Patients usually are retained until such vital signs as respiration, blood pressure and temperature have been stabilized, and sometimes until the first post-operative sedative has been administered or until the post-operative fluid therapy has been completed, which may be 30 minutes, five hours, or sometimes overnight. It has been found by hospitals operating recovery room units that the length of stay in the recovery room is generally equivalent to the time spent in the operating room. The surgeon, anesthesiologist, or designated resident decides when the patient's condition warrants his release to the nursing unit. Sometimes the availability of nursing staff or special equipment on certain nursing units may warrant the retention of certain patients in the recovery room overnight. Some hospitals limit the use of the recovery room to daytime hours, but continuing service in this unit at night is of inestimable value, since the nursing staff at night is much more limited on patient units than at any period of the day. Condition of the patients and the care required, rather than the time of day, should determine the need for recovery room service. Patients who have emergency operations at night require the same skilled care and service as day surgical patients. Providing for their care in the recovery room at night also avoids disturbing other patients throughout the hospital.

A telephone call to the nursing unit from the recovery room nurse advising the nursing staff of the return of the patient expedites continuity of care and avoids confusion.

Staffing: The over-all functioning of the unit and quality of patient care are dependent upon efficient nursing care by qualified nurses. The recovery room should be under the direct supervision of a graduate registered nurse experienced and interested in the care and management of post-operative surgical patients. The location of the unit, the administrative structure of the nursing service department, and the personal qualifications or workload of the nursing supervisors determine the assignment of the over-all nursing supervision of the recovery room. It may be either the operating room supervisor or the supervisor of the surgical patient areas. The latter is more usual.



To plan and maintain for economical usage of personnel throughout a hospital requires establishing a policy for hours of service in the unit: Either daily closing of the unit at the close of a day shift or retaining such patients as require special attention over a 24-hour period. When personnel time is planned a week in advance and operative loads cannot be determined until the day prior to surgery, projected staffing is difficult. Borrowing personnel from already heavily taxed patient units disrupts planning in these units and leads to personnel dissatisfaction. Although it is considered advisable to provide 24-hour service in a recovery room, hospitals not able to provide such coverage should not give up considering the establishment of a recovery room service. In some hospitals where the greater number of surgical operations are performed in the forenoon, daytime recovery room service would suffice for most surgical patients. The period 8:00 A.M. to 8:00 P.M. is the most urgent period. It is far better that the larger proportion of a hospital's surgical patients receive the recovery room protection in the daytime than that all of the surgical patients be deprived of the service.

Patients in the recovery room should never be left unattended, and the attending personnel must in all cases be competent. The assignment of a regular staff of nursing personnel rather than a rotating group from other portions of the hospital is desirable in the interest of efficiency of the service and best patient care.

The number of nurses and other personnel required to staff the unit is dependent upon the number of patients in the unit at different times of the day, the proximity of the patients, the length of time the patients remain in the unit, the amount and kind of care and treatment required, and the service provided from other units, especially the central supply department.

Recovery room nursing staff

General Hospital Beds	Operating Rooms[1] (Total No.)	Operations[2] per day	Recovery Beds	Recovery Patients	Staff[3] Daytime R.N.	Staff[3] Daytime Ns.A.	Attendants or Orderlies	Patients	Staff Evening R.N.	Staff Night R.N.
50	2	5	3	3	1	*	*	0		
100	3	10	4	4	1	1	*	0		
200	5	20	7	7	2	1	*	2	1	1
300	7	25	9	9	2	1	1	3	1	1
400	9	30	12	12	3	1	1	4	1	1
500	11	35	13	13	3	1	1	5	1	1

*As required on call or assigned from nearby unit.
1. Based on number of operating rooms in "Elements of the General Hospital," U. S. Public Health Service.
2. Based upon American Hospital Association surgical operation figures in HOSPITALS, June 1950, Part II, p. 58.
3. Based upon 1 registered nurse per 4 patients.

Usually one nurse experienced in the post-operative care of surgical patients, with the assistance of a nurse aide or orderly, can care for four patients, if supplies and equipment are provided assembled ready for use from a central supply unit. The telephone and intercommunicating call systems provide a means for calling additional help and summoning a physician when needed.

The hours of duty for the nursing personnel are usually arranged to provide the best coverage during the busiest time of the day. For example, in a 200 bed hospital, with a seven-bed recovery unit, utilizing the nursing staff as recommended to give the best coverage during the busiest period, which is usually between 9:30 A.M. and 4:00 P.M., the schedule could be:

8:00 a.m.	to	4:30 p.m.	—	1 R.N.
8:30 a.m.	to	5:00 p.m.	—	1 R.N.
9:30 a.m.	to	6:00 p.m.	—	1 nurse aide
4:30 p.m.	to	12:00 a.m.	—	1 R.N.
12:00 a.m.	to	8:00 a.m.	—	1 R.N.

Male orderly or attendant as required on call, or assigned for a portion of the day.

The nurse aide and orderly on duty at the end of the day clean equipment and assist with the preparation of the unit for the next day.

The nurse or nurses on the evening and night shift provide care for day surgery patients retained in the unit overnight and for night emergency operations.

Private practice nurses usually are not required for patients while in the recovery room when the unit is adequately staffed with qualified nursing personnel. When employed, they care for their patients under the direction of the recovery room nurse.

Training: All personnel assigned to recovery room duties should be well trained and assigned responsibilities commensurate with their education, experience and training. Training programs should include subject matter such as anesthetic agents and surgical procedures with special emphasis on the nursing care aspects, including symptoms and treatment of shock, hemorrhage, and asphyxia; the positioning of patients, maintenance of unobstructed airways, and the use of special apparatus and equipment, especially oxygen therapy, suction, tracheal tubes, urologic tidal drainage, thoracic and gastric suction, and the administration of blood and parenteral fluids. Student nurses and a sufficient number of graduate staff nurses to provide a nucleus of trained recovery room nursing personnel should be included in the training programs and assigned to the unit on a rotating basis. Hospitals initiating a recovery room service will find planned observation or experience for the nurse in another hospital's recovery room worth while.

PHYSICAL FACILITIES

Location: The recovery room is best located on the same floor and adjacent to the operating room suite to permit minimum immediate post-operative transportation, and to facilitate prompt post-operative care and treatment. The surgeons and anesthesiologists are readily available to observe and care for their patients between other surgical procedures and can be obtained for emergencies without delay. In small hospitals (fewer than 50 beds) requiring two or three recovery room beds, where the operating room is a distance from the nursing units, isolated recovery units sometimes present staffing problems. In these hospitals a unit located on the surgical patient unit, near the nurses' station, may be advisable.

Size: The size of the recovery room is dependent upon the maximum number of patients to be accommodated at one time, which is determined by the number, type, and duration of operations and the anesthetic agents used. The scheduling of operations and primarily the policy and practice relative to the use of the room for all or a selected number of surgical patients, and the length of time the patients are kept in the unit also influence the area required. Any hospital planning to include recovery room service should carefully study all the aspects of its service before determining the size. Since a new hospital will not have data relative to surgical operations and existing practices, plans have to be based on anticipated needs and practices and information obtained from hospitals of like size and type which operate recovery rooms. On the basis of information collected from hospitals operating surgery recovery rooms it was found that in hospitals having from one to four operating rooms the need for recovery beds is usually one bed for each operating room plus one; hospitals having from five to eight operating rooms require one re-

covery bed for each operating room plus two; and hospitals having from nine to twelve operating rooms require one recovery bed for each operating room plus three. On the basis of this information the following number of recovery beds is recommended.

Number of Recovery Beds[1]

Hospital beds	50	100	200	300	400	500
Total operating rooms[2]	2	3	5	7	9	11
Total operations per day[3]	5	10	20	25	30	35
Recovery beds	3	4	7	9	12	13

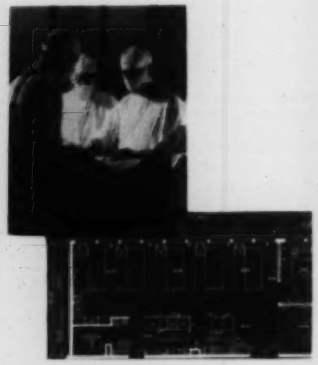
1. Based on: 1 to 4 operating rooms require 1 recovery bed plus 1. 5 to 8 operating rooms require 1 recovery bed plus 2. 9 to 12 operating rooms require 1 recovery bed plus 3.
2. Based on number of operating rooms in "Elements of the General Hospital," U. S. Public Health Service.
3. Based on American Hospital Association surgical operation figures in HOSPITALS, June 1950, Part II, p. 58.

Construction and arrangement: The recovery room unit should be arranged in such a manner that all patients can be observed simultaneously with a good view of their faces. An open ward with curtains to afford privacy only when needed has been found most satisfactory. A small area separated from the rest of the room by a glass partition, large enough to accommodate at least one patient, is desirable, for it is sometimes advisable to separate a patient because of sex, age, noise, infection, critical or expiring condition.

For each bed, sufficient area should be allowed to permit space for special bulky equipment and to afford access of personnel on all sides of the bed, including the head. One foot of space at the head of the bed and four feet between beds is a recommended minimum.

The entrance door should be wide enough to permit the entrance of beds with special apparatus. A double door is recommended. Windows six feet above the floor provide safety and permit flexible arrangements of beds and equipment.

The general construction of the unit should conform to acceptable standards of hospital construction. Soundproofing will minimize noise. Conductive floors are not required since flammable anesthetic agents are not used in the recovery room and a safe period of time elapses after the anesthetic is discontinued before the patient arrives in the unit.



A glass partition or large glass window separating the utility unit from the patient area minimizes noise and provides maximum observation of patients. The utility room should include work space for preparation of materials required for patient care; a sink, preferably double compartment, for cleansing utensils and equipment; and storage cabinets for solutions, medicine, treatment trays, utensils, and cleaning supplies. Wherever possible, work areas should be arranged so workers face toward the patients. A small refrigerator is required for the storage of thermolabile drugs and biologicals, and to provide ice for ice packs and compresses. If a larger amount of ice is required a portable ice storage truck may be indicated, or ice may be delivered from a nearby unit.

A sterilizer, preferably steam pressure type, should be included in the utility room when the hospital central sterile supply room does not furnish complete service, including treatment trays, syringes and needles, and when a sterilizer is not available in a nearby utility unit for utensil and bed pan sterilization.

A clinical sink with bed pan flushing attachment for disposal of excreta is best located separately from the utility room.

Storage space should include cupboards for medicines, linens, blankets, treatment trays, and space for large pieces of equipment such as oxygen tent, bed rails, portable suction machine, oxygen therapy equipment, resuscitator, and inhalator.

The nurse's desk should be placed to afford a view of all patients.

Toilet facilities and a water cooler or fountain should be provided for personnel except where available nearby.

Lighting: Adequate lighting, either natural or artificial, should be provided to afford a good view of the patient's color. When artificial lighting is used, an indirect filament lamp lighting system is recommended for best color observation. Lighting should be fairly uniform throughout the room. The intensity at 30 inches above the floor should be at least 20 footcandles, and preferably 30 footcandles. It is desirable that the lighting system be so arranged that the intensity may be varied. Separately switched fixtures, or fixtures with more than one lamp on separate circuits are suggested. Some emergency lighting should also be provided.

Electrical: A sufficient number of electrical outlets for convenient use should be provided. At least one duplex receptacle for each bed and one heavy duty receptacle within the unit for a portable x-ray machine is recommended. The heavy duty outlet should match those in the corridors which are usually 20-ampere, 3-wire polarized.

Communications: A telephone and emergency call system should be provided as a means of summoning physicians or additional nursing personnel when needed. One or more wall type emergency call buttons should be so connected to register in the operating room suite and the nearest nursing unit. Individual call bells or lights are usually not required for each patient, since most of these patients are usually not able to use them. Also, a nurse is always in the area, and the unit is small. In large recovery units, it is sometimes advisable to provide call bells, electrical or hand type, for some patients can warn the nurse of impending symptoms and to some patients it affords reassurance. The telephone bell should be dampened to minimize noise.

Oxygen and suction: Oxygen and suction outlets should be provided for each patient with the control

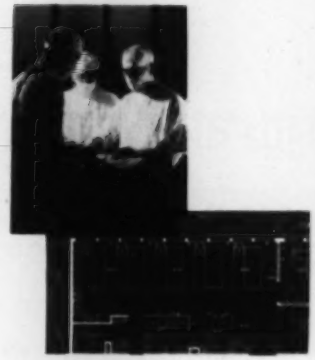
and humidifier bottle located 5' 3" high so they can be easily reached, and high enough to avoid damage by the head of the bed. The oxygen piped from either a central supply system or a manifold system adjoining the recovery room should be installed according to the recommendations of the National Fire Protection Association in NFPA Publication No. 565. A central suction system is preferred. Each suction and oxygen outlet should be gauge controlled and the suction and humidifier bottles fastened to the wall on a small shelf or metal holder. When hospital plans and construction do not permit central oxygen or suction systems, portable equipment can be made available as needed.

Temperature and humidity: The temperature and relative humidity of the room should be maintained within the average comfort range which in winter is usually about 72 degrees F. and 40-50 per cent relative humidity. Controlled air conditioning is desirable. Especially in summer and when the operating rooms are air conditioned, care should be taken to avoid temperatures of more than 20-degree differential from the outdoors.

Plumbing: Plumbing should include hot and cold running water for hand washing, cleaning equipment, and disposal units for excreta.

Equipment and supplies: The availability and completeness of well maintained equipment and supplies are important factors in the effectiveness of the recovery room service. Though some life-saving items of equipment may not be used often, their presence in the recovery room is as important as a life raft on a ship or a fire extinguisher in a building. The quantity of some items kept in the recovery room depends somewhat upon their availability and delivery from the central supply room, pharmacy, store room, operating room and nearby nursing unit, but it is necessary to maintain at least a 24-hour supply of all items in the recovery room ready for use at all times.

Furnishing a recovery room is largely a matter of reassigning items of supply and equipment



now in use in an operating hospital or on the equipment list for a new hospital. Some items of special equipment or additional quantities may be required.

The equipment and supplies for adequate recovery room services should include:

1. Oxygen, blood pressure, and suction units either fixed or portable, for each patient; and at least one additional small portable oxygen and suction unit which is sometimes required while transporting a patient to his room in emergencies, or should the central system fail.

2. Equipment to administer oxygen, including humidifiers, tents, masks, gauges, and catheters.

3. Suction tubes and catheters.

4. Resuscitator and inhalator.

5. Gastric, bladder and chest drainage apparatus.

6. An ice storage unit and refrigerator to store antibiotic solutions, thermolabile drugs and in some instances blood, and to provide ice for compresses, ice caps, and oxygen tent.

7. A clinical sink for excreta and waste disposal; sink and work space for cleaning equipment.

8. A pressure sterilizer, which is necessary only in hospitals where the central supply room service does not provide all sterile supplies, including syringes, needles and instruments, and where sterilizing equipment is not accessible in a nearby utility room for the sterilization of utensils such as wash basins, emesis basins and bed pans.

9. A desk with the necessary supplies and equipment and several chairs for use by the physicians and nurses when preparing records.

10. A telephone and emergency call system with signals in the operating suite and nearest nursing unit.

11. For each patient one bedside table or stand with a drawer and towel rack, equipped with bed pan, wash basin, emesis basin, towel, cup, suction catheter, lubricating jelly, tongue blades, record sheet, mouth wipes, bandage, adhesive, rubber bands, safety pins, and toilet paper.

12. For each patient one bed or stretcher with rubber covered mattress, which is adjustable to various positions, equipped with intravenous stands at both head and foot, and with siderails.*

13. Child's crib, adjustable, equipped with rubber covered mattress, side rails, and intravenous stands, when required for children.*

14. Bed rails, shock blocks, bed elevators and intravenous standards, required only when the beds or stretchers provided are not equipped with these attachments.

15. Mobile surgical or treatment light.

16. Linen hamper.

17. Waste containers.

18. Clock, electric, with sweep hand.

19. Medicine cupboard with inner locked space for narcotics.

20. Linens, blankets, pillows and protective coverings.

21. Cleaning supplies and equipment.

22. Small instrument table.

23. Small dressing carriage with the necessary equipment and supplies.

24. Utensils, including wash basins, mouth wash cups, emesis basins, bed pans and urinals.

25. Sterile solutions for irrigations and parenteral use. Blood and plasma are usually ordered as required.

26. Medications including cardiac and respiratory stimulants, sedatives, and antibiotics.

27. Oral and nasal air ways, pharyngeal, tracheal and nasal catheters.

28. A laryngoscope, mouth gags, and tongue blades, and in some instances bronchoscopic equipment.

29. Sterile syringes and needles.

30. Stethoscopes.

31. Arm boards and sand bags.

32. Ice caps and hot water bottles.

33. Tanks of oxygen and helium mixtures.

34. Treatment trays and sets including:

a. Intravenous sets;

b. Blood transfusion and plasma sets;

c. Phlebotomy trays including cut-down sets;

d. Dressing sets;

e. Hemorrhage sets;

f. Thermometer tray;

g. Hypodermic tray;

h. Gastric, bladder and chest drainage sets;

i. Tracheotomy tray;

j. Catheterization trays;

k. Urethral retention catheter sets;

l. Gastric or intestinal tubes;

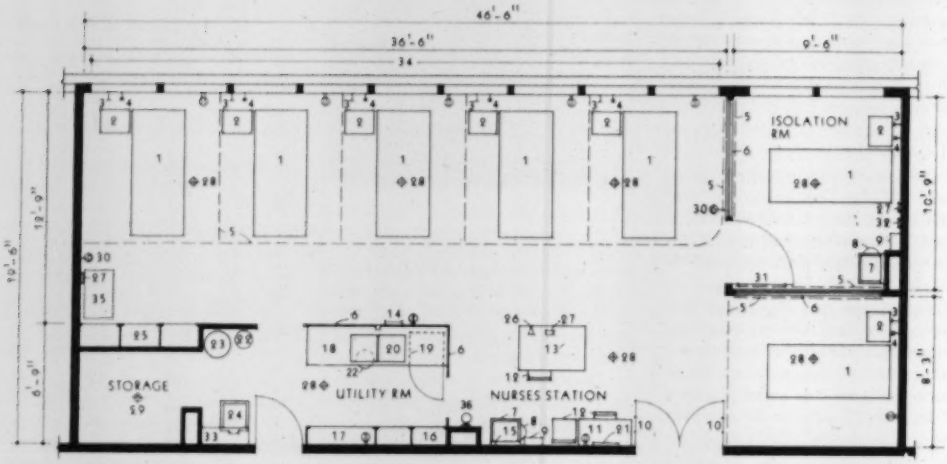
m. Morgue sets.

35. Tourniquets.

36. Fire extinguishing equipment.

*May be omitted when patients are sent to the recovery unit in their own beds, but the same attachments should be furnished.

The following floor plan and detailed equipment list are suggested for a 200-bed general hospital.



SURGERY RECOVERY ROOM FOR A 200-BED GENERAL HOSPITAL

FEET

1. Adjustable hospital bed
2. Bedside cabinet
3. Oxygen outlet, 5 feet 3 inches above floor
4. Suction outlet, 5 feet 3 inches above floor
5. Cubicle curtain
6. Partition to ceiling, glass 40 inches above floor to 7 feet above floor
7. Lavatory with gooseneck spout and knee or elbow control
8. Waste paper receptacle
9. Paper towel dispenser
10. Vision panel
11. Table
12. Straight chair
13. Executive type desk
14. Clock
15. Mirror
16. Locked wall cabinet with inner locked narcotic compartment and inside light
17. Shelf, 12 inches wide, 38 inches above floor with cabinets above and below
18. Work counter, 2 feet 4 inches wide, 38 inches above floor
19. Refrigerator under counter
20. Double compartment sink, one compartment 6 inches deep, the other 10 inches deep, gooseneck spout
21. Bulletin board
22. Sanitary waste receptacle
23. Laundry hamper
24. Clinical sink with bedpan flushing attachment
25. Storage cabinet
26. Telephone outlet
27. Nurses' call with emergency call button with duplex receptacle
28. 500-watt indirect lighting units
29. 200-watt semidirect lighting unit
30. Single receptacle 30 amps.
31. Glazed door
32. Hook strip
33. Shelf 48 inches above floor
34. Window sills approximately 6 feet above floor
35. Dressing cart
36. Fire extinguisher, 2.5 gal. water (stored pressure type)

SUGGESTED EQUIPMENT AND SUPPLY LIST

FOR A 7-BED RECOVERY UNIT

Recovery Unit

Group I Equipment[†]

	Suggested Quantity
Blinds, window	
Bulletin Board, 26 x 24 inches	1 ea
Clock outlet, with electric clock	1 ea
Cubicle curtains and rod	9 ea
Dispenser, paper towel	2 ea
Dispenser, soap	2 ea
Extinguisher, Fire, 2½ Gal. water (stored pressure cartridge type)	1 ea
Lavatory, elbow or knee control	2 ea
Mirror over lavatory	2 ea
Outlet, electric, heavy duty for portable x-ray	1 ea
Outlet, emergency call	1 ea
Outlet, oxygen, central system, complete with regulators, gauges, and humidifiers[1]	7 ea
Outlet, suction, central system, complete with regulators, gauges and receptacle[2]	7 ea
Shelf, over lavatory	2 ea
Telephone outlet	1 ea

Group II Equipment

Beds, adjustable, or special recovery room stretchers, with side rails and standards[3]	7 ea
Cabinet, bedside	7 ea
Cribs[4]	
Chair, straight	3 ea
Desk, office	1 ea
Holder, chart to fit desk	1 ea
Light, examining	2 ea
Lamp, desk	2 ea
Mattress[5]	7 ea
Mattress, crib[5]	
Sphygmomanometer	5 ea
Table, instrument, 16 x 20 inches	1 ea
Table, office with drawer, 24 x 36 inches	1 ea

Utility Room and Storage

Group I Equipment

Cabinet, wall, locked with inner locked narcotic compartment	1 ea
Cabinet, storage[6]	1 ea
Counter, 38 inches high	1 ea
Dispenser, paper towel	1 ea
Dispenser, soap	1 ea
Light, general illumination	1 ea
Outlet, electric, double receptacle	1 ea
Shelf, 12 inches wide, 38 inches above floor with cabinets above	1 ea
Sink, double compartment, one comp. 6 inches deep, the other 10 inches deep	1 ea
Sink, clinical with bedpan flushing attachment	1 ea

Group II Equipment

Can, waste, foot lever	2 ea
Carriage, dressing, small	1 ea
Elevators, bed (shock block)[7]	7 ea
Drainage apparatus, surgical, electric or gravity	2 ea
Hamper, laundry	1 ea
Inhalator, steam, electric	1 ea
Irrigator, drainage, chest	1 ea
Irrigator, tidal bladder	1 ea
Oxygen, portable apparatus, small cylinder, gauge, humidifier and stand	1 ea
Oxygen, tent	1 ea
Rails, bedside[8]	7 pr
Refrigerator and ice storage	1 ea
Resuscitating apparatus, complete with gas cylinders	1 ea
Stand, parenteral solution[9]	14 ea
Suction, apparatus, electric, portable	1 ea

Group III Equipment

Medical and Surgical

Armboards	7 ea
Bag, rubber, throat	3 ea
Basin, emesis, deep, 8 x 2 inches	12 ea
Basin, wash, shallow, 13 inches, O.D. 4¼ quart	12 ea
Bedpan, adult	7 ea
Bedpan, child	1 ea
Bottle, rubber, hot water-ice, combination	12 ea
Bottles, for irrigation and drainage apparatus	3 ea
Bowl, sponge, straight sides, 4½ inches, O.D. 1 pint	6 ea
Can, metal, sifter top, screw cap, 3 inches high	7 ea
Catheter, metal, female	2 ea
Catheter, rubber, green, oxygen, sizes, Fr. 8-12-14	12 ea size
Catheter, rubber, soft, urethral, assorted sizes, (Fr. 8—Fr. 22)	12 ea size
Catheter, tracheal—assorted sizes and connections	1 ea size
Clamp, screw, rubber tubing	12 ea
Cup, solution, 6 oz.	12 ea
Dish, metal, soap	7 ea
Dropper, medicine	12 ea
Flashlight	2 ea
Gloves, rubber, assorted sizes	6 pr. ea. size
Irrigator, metal with handles, 2 quart	2 ea
Jar, metal, dressing, with cover 1 quart	3 ea
Jar, metal, forceps, 8 x 2 inches	2 ea
Masks, oxygen, face, medium, oronasal type	7 ea
Masks, oxygen, face, small oronasal type	7 ea
Measure, graduated, metal, double scale, 500 ml. 16 oz.	1 ea
Medicine, glass, 2 oz.	12 ea
Pin, safety, medium, #2	1 gross
Pitcher, metal, small, medicine tray	1 ea
Rack, wall, metal, drying, rubber tubing	1 ea
Razor, safety	1 ea
Sets, blood transfusion administration	3 ea
Sets, intravenous solution administration	12 ea
Sheeting, rubber or substitute, heavy weight, 36 inches wide	24 yds
Sheeting, rubber or substitute, light weight, 36 inches wide	3 yds
Syringe, glass, irrigating, 4 oz. with bulb	3 ea
Syringe, glass, Luer, 1½ cc.	24 ea
Syringe, glass, Luer, 5 cc	12 ea
Syringe, glass, Luer, 10 cc	12 ea
Syringe, Luer, 50 cc	2 ea
Thermometer, clinical, mouth	6 ea
Thermometer, clinical, rectal	12 ea
Tourniquet	6 ea
Tray, metal, with cover, catheter, 8½ x 3 x 1½ inches	1 doz
Tube, glass connections, straight	½ doz
Tube, glass, drinking	1 doz
Tube, rubber, colon, assorted sizes	1 ea
Tubing, rubber, ¼ x 1/16 inch	18 yds
Urinal, metal, male	3 ea
Wrench, oxygen-gauge	7 ea

Instruments

Airway, metal, Connell, large	12 ea
Airway, metal, Connell, small	6 ea
Blade, operating knife, No. 10, 6s	½ doz
Forceps, hemostatic, curved, Kelly, 5½ inches	¼ doz
Forceps, hemostatic, curved, Rochester-Pean, 6¼ inches	½ doz
Forceps, hemostatic, mosquito, curved, Halstead	¼ doz
Forceps, hemostatic, straight, Kelly, 5½ inches	¼ doz
Forceps, thumb, plain, dressing, 6 inches	3 ea
Forceps, thumb, plain, dressing, 10 inches	2 ea
Forceps, tissue spring, 6 inches, 1 x 2 teeth	3 ea
Forceps, tongue holding	1 ea
Forceps, uterine, dressing, 10 inch	1 ea
Knife, handle, operating, No. 3	2 ea
Laryngoscope, Battery type	1 ea
Needles, hypodermic, regular, Luer, 22 gauge, 1½ inches	2 doz
Needles, hypodermic, regular, Luer, 25 gauge, 5/6 inches	3 doz

Needles, hypodermic, regular, Luer, 20 x 1½ inches — 2 doz
Needles, suture, surgeons, regular, ⅜ circle, cutting edge, size 12 — ½ doz
Scissors, bandage, Lister — 2 ea
Scissors, operating, curved, blunt, 5 inches — 2 ea
Scissors, operating, curved, one point sharp, 5½ inches — 2 ea
Stethoscope — 3 ea
Tube, suction, Frazier, 8 Fr. — 7 ea
Tube, suction, tonsil and abdominal — 7 ea
Tube, trachea, Jackson, size #1 — 1 ea
Tube, trachea, Jackson, size #2 — 1 ea
Tube, trachea, Jackson, size #4 — 1 ea

Housekeeping

Bag, hamper, laundry — ½ doz
Bags, sand — ¼ doz
Basin, cleaning — 1 ea
Brush, bed pan — 1 ea
Brush, hand, surgery — ½ doz
Binder, abdominal, medium — ½ doz
Binder, breast, medium — ¼ doz
Binder, scultetus — ½ doz
Binder, T, Male — ½ doz
Binder, T, Female — ½ doz
Blanket, bed, wool, 72 x 90 inches — 1 doz
Cover, mattress, size 45 x 81 x 9½ inches — 1 doz
Cover, rubber or plastic, large pillows — 1 doz
Cover, hot water-ice combination — 1½ doz
Gown, isolation — ½ doz
Gown, patient, large — 2 doz
Gown, patient, small — ½ doz
Masks, surgical — 1 doz
Pillow, 21 x 27 inches, medium — 1½ doz
Pillow case, 45 x 36 inches — 4 doz
Sheet, bed, 108 x 72 inches — 4 doz
Sheet, draw, size 54 x 72 inches — 4 doz
Sheets, post-mortem — 1/6 doz
Towel, bath, patients, 22 x 44 inches — 2 doz
Towel, hand and face, 16 x 32 inches — 2 doz
Towel, surgical, 18 x 36 inches — 1 doz
Washcloth — 2 doz

Office

Basket, waste paper — 3 ea
Binder, loose-leaf, 1 inch rings for paper — 1 ea
Ink wells — 2 ea
Pad, calendar — 1 ea
Pad, desk — 1 ea
Ruler, 12 inch — 1 ea
Sharpener, pencil — 1 ea

Supplies

Medical and Surgical

Applicator, cotton tip, 3 inches, small tip — 2 doz
Bandage, elastic, 3 inches x 3 yds. roll — ¼ doz
Bandage, gauze, rolled, 4 inches x 10 yds — ½ doz
Bandage, gauze, rolled, 3 inches x 10 yds — ½ doz
Bandage, gauze, rolled, 2 inches x 10 yds — ½ doz
Bandage, gauze, rolled, 1 inch x 10 yds — ½ doz
Battery, flashlight — 3 ea
Bulbs, flashlight — 3 ea
Bulbs, laryngoscope — 3 ea
Blade, safety razor, double edge, 100 — 1 doz
Cap, paper for urine specimen bottles — 1 doz
Depressor, tongue — 1 doz
Dressing, gauze and adhesive, ready made, ¾ x 3 inches — 2 doz
Pad, cotton, perineal — 2 doz
Pad, eye, dressing — ½ doz
Plaster, adhesive, 12 inches x 10 yard cut — 1 roll
Sponge, 2 x 2 inches, gauze with web of cotton — 10 doz
Sponge, 3 x 3 inches, gauze with web of cotton — 10 doz
Sponge, 4 x 4 inches, gauze with web of cotton — 10 doz
Stick, orangewood — 1 doz
Suture, catgut, plain, Type A, size 0 — ½ doz
Suture, silk braided, size 0 — 1 spool

Drugs and Chemicals

Alcohol, Ethyl, denatured — 1 pt
Alcohol, 5%, w/v Dextrose 5% w/in isotonic sodium chloride solution, 1000 cc — 2 bot
Amino acid injection, 5% in dextrose solution, 5%, 1000 cc — 3 bot
Amyl nitrite, fragile ampuls, 0.3 cc. (5 min.) — 3 ea
Atropine sulfate tab'ets, hypo., 0.4 mg., (1/150 gr.) — 1 doz
Atropine sulfate tab'ets, hypo., 0.6 mg., (1/100 gr.) — 1 doz
Boric acid ointment, ophthalmic, 5%, ⅛ oz. — 1 tube
Boric acid ointment, USP, 1 oz. — 1 tube
Caffeine and sodium benzoate injection, 0.25 Gm. (3¾ gr.), 2 cc. — 12 ampul
Codeine phosphate injection, 30 mg. (½ gr.) per cc., 20 cc. or tablets, hypodermic — 1 vial
Collodion, flexible, USP — 2 oz
Nikethamide injection, USP, 25% W/V: 1.5 cc. — 20 ampul
Meperidine hydrochloride injection, USP, (Demerol) 50 mg. per cc., 2 cc. — 12 ampul
Dextrose injection, 5% in isotonic sodium chloride solution, 1000 cc. — 12 bot
Dextrose injection, 10% in isotonic sodium chloride solution, 500 cc. — 6 bot
Dextrose injection, 50%, 50 cc. — 2 ampul
Digitalis injection — 12 ampul
Ephedrine sulfate injection, 50 mg., (¾ gr.) 1 cc. — 12 ampul
Epinephrine injection, USP, 1-1000, 1 cc. — 6 ampul
Ergotamine tartrate injection, 0.5 mg., (1/120 gr.) 1 cc. — 2 ampul
Lubricating jelly — 10 tubes
Antiseptic, tincture, skin sterilization — 1 pint
Morphine sulfate injection, 15 mg. (¼ gr.) per cc., 20 cc. or tablets hypodermic — 1 vial
Phenylephrine, hydrochloride solution (neosynephrine) 1%, 1 cc. — 24 ampul
Oxygen, 95% and carbon dioxide, 5%, "B" cylinder — 1 cyl
Oxygen, 20% and Helium, 80%, cylinder — 1 cyl
Oxygen, USP, "D" cylinder (95 gal.) — 1 cyl
Oxygen, USP, "E" Cylinder (165 gal.)[10]
Vasopressin injection, USP, pitressin 1 cc. — 6 amp
Penicillin, for injection, rapid, 100,000 units[11] — 12 vial
Penicillin, for injection, prolonged, 300,000 units per cc., 5 cc.[12] — 1 vial
Pentobarbital sodium capsules, 0.1 Gm. (1½ gr.)[13] — 1 doz
Petrolatum, white, USP, 1 oz. — 1 tube
Phenobarbital tablets, 15 mg., (¼ gr.) — 1 doz
Phenobarbital tablets, 0.1 GM., (1½ gr.) — 1 doz
Neostigmine methyl sulfate injection, USP, 1-2000, 1 cc. — 12 ampul
Neostigmine methyl sulfate injection, USP, 1-4000, 1 cc. — 12 ampul
Plasma, normal human dried, 500 cc., and equipment[14] — 2 pkg
Procaine hydrochloride, solution, 1% — 4 oz.
Sodium chloride solution, isotonic, USP, injection 1000 cc. — 6 bot
Talcum, USP — 1 lb
Water for injection, USP, 50 cc. — 2 amp

Housekeeping

Cloth, cleaning, cheese cloth — 2 yds
Bag, paper, 2 lb. — 4 doz
Germicide — 1 qt
Paper, tissue, mouth wipe, boxes — 4 doz
Paper, tissue, toilet — ¾ doz rolls
Soap, scouring powder — 1 lb
Soap, toilet, 2 oz. — 1 doz

Office

Blotter, desk — 1 ea
Blotter, hand — ½ doz
Eraser, pencil and ink — ½ doz
Forms
- Special service charge slips
- Room occupancy records
- "Critical List" forms
- Death certificates
- Blood transfusion
- Clinical record identification date sheet
- Graphic chart
- Physician's orders for treatment
- Nurse's notes
- Physician progress notes
- Anesthesia records
- Accident reports
- Permit for autopsy
- Request for x-rays
- Request for laboratory tests
- Room occupancy records
- Morgue tags
- Prescription blanks
- Requisitions
- Pharmacy
- Central Supply
- Store room
- Maintenance and report
- Linen room
- Dietary
- (Any other special form or requisition as required by the individual hospital)

Ink, writing, black, bottle — 1 ea
Ink, writing, red, bottle — 1 ea
Pad, memorandum, 3 x 5 inches — 1 doz
Pad, scratch, 3 x 5 inches — 1 doz
Pen, steel — ½ doz
Pencil, lead — ½ doz
Pen holder — ¼ doz
Rubber bands, box — 1 ea

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1. Portable apparatus with stand may substitute.
2. Portable apparatus may substitute.
3. Either may be omitted when patients are sent from operating room in own beds.
4. May be omitted when patient arrives in own bed.
5. As required.
6. Free standing may substitute.
7. May be omitted if adjustable beds equipped to elevate.
8. May be omitted when beds are equipped with rails.
9. May be omitted when beds are equipped with adequate standards.
10. Oxygen piping system may be substituted.
11. Also available in 200,000, 500,000 and 1,000,000 unit vials.
12. Available in 10 cc vial and 1 cc cartridge sets.
13. Other barbiturate preparations of similar action may be substituted.
14. Or equivalent in liquid plasma if available.

References

1. Anderson, C. D., and Miller, E. M., "Post Anesthesia Unit in the Private Hospital," HOSPITALS, Oct. 1949, Vol. 23, p. 89.

2. Bickerman, H. A., M.D., "A Review of Inhalation Therapy," *Journal of the American Association of Nurse Anesthetists*, May 1948, Vol. 16, pp. 123-131.

3. Booth, Shirley C., R.N., "Recovery Room Service," *American Journal of Nursing*, June 1951, Vol. 51, No. 6, p. 359.

4. Carnahan, Julie M., R.N., "Recovery Room for Post Operative Patients," *American Journal of Nursing*, Sept. 1949, Vol. 49, pp. 581-582.

5. Charbon, H. G. A., M.D., and Livingstone, H. M., M.D., "Planning a Recovery Room for Adequate Post Operative Care," HOSPITALS, Aug. 1949, Vol. 23, pp. 35-38.

6. Conboy, Catherine F., R.N., "A Recovery Room," *American Journal of Nursing*, Oct. 1947, Vol. 47, pp. 686-687.

7. Eliason, E. L., M.D., Ferguson, L. K., M.D., and Sholtis, Lilian A., R.N., "Recovery Room," *Surgical Nursing*, 9th Edition, p. 81. J. B. Lippincott Co., Philadelphia, 1950.

8. Fitzgerald, E., R.N., Geiger, E., R.N., Ryan, W., and Terrenzio, L.L.B., "Survey of Current Practices in Recovery Rooms," May 1951. An unpublished paper, Columbia University School of Public Health, Program of Hospital Administration and Teachers College, Division of Nursing Education.

9. Griffith, Harold R., M.D., "Recovery Room," *The Canadian Nurse*, Oct. 1950, Vol. 46, No. 10, pp. 791-792.

10. Hebert, C. L., M.D., and Massengill, C. K., M.D., "The Postanesthetic-Post Operative Recovery Ward," Depts. Surgery and Anesthesiology, U. S. Marine Hospital, Staten Island, New York. An unpublished paper adapted from the article in *Bulletin of the Richmond County Medical Society*, Feb. 1949.

11. Honey, Elva, B.N., "Post-Anesthetic Recovery Rooms," *The Canadian Nurse*, June 1950, Vol. 46, No. 6, pp. 465-470.

12. Hudenberg, Roy, "Recovery Suite" (Service from Headquarters), HOSPITALS, August 1948, Vol. 22, No. 8, pp. 28-29.

13. Kelly, Winifred, R.N., "Recovery Room—Beth Israel Hospital, Boston, Mass.," *ORS*., June 1951, pp. 10-11.

14. Kerns, Rosemary, R.N., "Post-Anesthesia Recovery Room," *Hospital Progress*, Dec. 1949, Vol. 30, No. 12, p. 374.

15. Leigh, M. Digby, M.D., and Masters, G. E., "Modern Post-Anesthesia Recovery Room Service," *The Canadian Hospital*, Sept. 1949, Vol. 26, No. 9, pp. 30-32.

16. Livingstone, H. M., M.D., and Light, G. A., M.D., "A Record for the Recovery Room," HOSPITALS, June 1949, Vol. 23, No. 6, p. 60.

17. Lundy, John S., M.D., and Gage, Robert P., "P.A.R. Spells Better Care for Post-Anesthesia Patients," *The Modern Hospital*, Nov. 1944, Vol. 63, No. 5, pp. 63-64.

18. Morgan, Dorothy M., "Nursing at the University of Chicago Clinics—Recovery Room," *Hospital Management*, July 1951, Vol. 72, No. 1, pp. 80-82.

19. "Dr. MacEachern's Mailbag," *Hospital Management*, Feb. 1950, Vol. 69, No. 2, p. 24.

20. McNearney, Joseph, M.D., "Status of Anesthesiologist on the Operating Room Team (Post-operative Care)," *Hospital Management*, April 1951, Vol. 71, No. 4, pp. 72-74.

21. Noble, A. B., M.D., "Practical Suggestions for A Small Hospital Recovery Room," *Hospital Progress*, Aug. 1948, Vol. 24, No. 8, pp. 272-273.

22. Sadove, Max S., M.D., Kretchmer, H. E., M.D., Wyant, G. M., M.D., Gittelson, L. A., M.D., and Puestow, C. B., M.D., "An Ideal Recovery Room," *The Modern Hospital*, Jan. 1951, Vol. 76, No. 1, pp. 88-96.

23. Sanders, R. Douglas, M.D., Atkins, James P., M.D., Savage, Gerald J., M.D., and Cooling, Jean B., R.N., Wilmington, Delaware, "Organization and Operation of a Recovery Room." An unpublished paper.

24. Tovell, R., M.D., and Steven, R. J. M., "Anesthesia and the Role of Anesthesiologists Today," *The Modern Hospital*, Nov. 1949, Vol. 73, No. 11, p. 60.

25. Wanro, N. W., M.D., "The Recovery Room Has Much to Recommend It," *The Modern Hospital*, November 1949, Vol. 73, No. 11, p. 65.

26. "Changes that Mean Progress in the Tuberculosis Crusade," HOSPITALS, October 1949, Vol. 23, No. 10, p. 89.

27. "Recovery Room Affords Better Care for Surgical Patients," *The Modern Hospital*, Sept. 1950, Vol. 75, No. 3, p. 70.

28. "Recovery Room Installed at St. Mary's Hospital, Minneapolis, Minnesota," *Hospital Progress*, May 1950, Vol. 31, No. 5, p. 96A.

29. "Recovery Rooms," *Medical Annals of the Dist. of Col.*, April 1951, Vol. XX, No. 4, p. 213.

30. "Standard for Nonflammable Medical Gas Systems," NFPA No. 565, 1951, National Fire Protection Association, International, 60 Batterymarch Street, Boston, Mass.

31. Weismiller, L. L., M.D., "Setting up a Post-operative Recovery Room," HOSPITALS, July 1950, Vol. 24, No. 7, pp. 49-52.

32. "Safety in Handling Compressed Medical Cases," *Surgical Equipment*, July 1951, Vol. 28, No. 3, pp. 2-45.

33. "Standards of Effective Administration of Inhalational Therapy," *Second Report by the Committee on Public Health Relations of the New York Academy of Medicine*. Reprinted with additions from the *Journal of the American Medical Association*, Sept. 2, 1950, Vol. 144, pp. 25-34.

34. Surks, S. N., M.D.; Pallin, I. M., M.D.; Hall, C. H., Jr., M.D.; Lipson, H. I., M.D.; "An Improved Recovery Ward," Veterans Administration Hospital, Brooklyn, New York. Exhibit presented at the 101st Annual Session of the American Medical Association Meeting, Chicago, Ill., June 9-13, 1952.

35. Lundy, John S., M.D., "A Cart for Use in the Postanesthesia Room or For General Hospital Use," *Proceedings of the Staff Meetings of the Mayo Clinic*, Rochester, Minnesota, June 4, 1952, Vol. 27, No. 12, pp. 234-235.

36. McMahon, Janet, R.N., and Fife, Gertrude L., R.N., "Nursing Problems in Recovery from Anesthesia," *American Journal of Nursing*, Aug. 1945, Vol. 45, No. 8, pp. 618-622.

37. Oschner, Alton, M.D., "Recovery Rooms Pay Dividends," *The Canadian Hospital*, Jan. 1951, Vol. 28, No. 1, pp. 43-44.

38. Leon, Sister Agnes, R.N.; "Postanesthetic and Postoperative Recovery Units," *American Journal of Nursing*, April 1952, Vol. 52, No. 4, pp. 430-434.

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A SPECIAL CASE STUDY

Activating a dormant public relations program

DONALD J. DUFF

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The story of how this has been accomplished constitutes a case study in public relations—an analysis of the problems faced by the hospital, and the steps taken to solve them. It is a story of careful planning followed by a program of action.

The Vancouver General Hospital, with more than 1,500 beds and bassinets, is Canada's largest general public hospital. Its 21 buildings cover nearly seven city blocks, and all major buildings are linked by nearly two miles of underground corridors. The hospital has more than 1,600 employees and 600 students in many different educational programs, including medical residents and interns, student nurses, dietetic interns, administrative residents and x-ray laboratory students.

The hospital serves as a clinical teaching center for the University of British Columbia Faculty of Medicine, and, in cooperation with the university's school of commerce, offers a program in hospital administration leading to a degree in commerce and a diploma in hospital administration. The hospital's school of nursing is the largest in Canada and the new residence for student nurses, with single bedroom accommodation for 575 students, has been acclaimed one of the finest on the continent.

Historically, the hospital dates back to 1886, the year Vancouver was founded. The hospital had its origin in a nine-bed wooden building constructed by the Canadian Pacific Railway to shelter sick and injured railway workmen. In the same year, 1886, it became known as City Hospital. In 1902, by an act of the government of British Columbia, the Vancouver General Hospital was incorporated as a voluntary, nonprofit institution serving the public at large.

The need for an active public relations program at the hospital had been apparent for some time, but it was not until 1950 that serious consideration was given to the idea of a planned and directed program. The director of the hospital, Mr. L. N. Hickernell, readily saw that the answer to the hospital's critics lay in a program of public education—a program for patients, visitors, doctors and employees. In the fall of 1950 the hospital's board of trustees interviewed applicants for the position of public relations director. The trustees, like the director of the hospital, were keenly aware of the need for a directed public relations program. The person chosen would be directly responsible to the director of the hospital and a member of the hospital's management committee.

Mr. Duff is public relations director at the Vancouver General Hospital, Vancouver, British Columbia, Canada.

PROGRAM PLANNING

The first step in planning the public relations program was a classification of the hospital's various "publics." The importance of this step cannot be overemphasized. As its major publics the Vancouver General Hospital lists: (1) patients and their visitors; (2) doctors; (3) employees; (4) newspapers, magazines and radio stations; (5) trustees, and life and annual members; (6) auxiliary organizations; (7) hospital suppliers; (8) health and welfare agencies, churches, schools, businesses and industries and their leaders and community organizations; (9) the general public.

It was felt that a public relations program designed to secure and maintain the support of these nine publics would, in time, achieve the desired objective—community-wide understanding and appreciation of the hospital and its services.

A public relations committee, active and interested in the program, is an invaluable asset. Its members can give breadth of view to the program, lend the benefit of specialized knowledge and help with specific projects. At the Vancouver General Hospital, the public relations committee is a standing committee comprised of two members of the board of trustees, the director of the hospital and the public relations director. The committee discusses suggestions and ideas for public relations projects, and, through the committee, proposed projects are submitted to the board of trustees for final consideration.

PRESS RELATIONS

The newspapers, magazines and radio stations were made the starting points for the program. Letters were sent to editors and radio station managers advising them of the hospital's new public relations department.

A series of luncheon meetings came next. Present were editors of Vancouver's three daily newspapers, the hospital's trustees and members of the medical board. Re-

lations between the doctors, the hospital and the press were discussed. Many problems were ironed out, and agreement was reached on many points. This direct and personal approach most definitely set the stage for improved press relations.

A series of articles about the hospital, to be released under the name of prominent trustees and published on the editorial pages, was suggested at one of the luncheon meetings. The suggestion met with immediate approval and was carried out. Considerable research went into the preparation of each article, and many of them have been reprinted in other publications.

Two of Vancouver's three dailies have Sunday supplements, and their editors expressed interest in feature articles about the hospital. Many have appeared. Early in the program, the newspapers' hospital and medical reporters were invited to lunch at the hospital, and taken on a tour of all departments. This resulted in greater understanding of the hospital on the part of the reporters, who wrote a number of feature articles, over a period of time, for the news pages.

News of new equipment, personnel changes, special courses, information regarding the hospital's construction program and other news items are issued regularly in press and radio releases.

The hospital endeavors to release only material which is newsworthy, to keep releases as short as possible and to write them in acceptable newspaper style. Newspapers usually prefer to take their own pictures, but whenever a release warrants a picture, it is accompanied by a photograph.

The public relations department has in its files nearly 200 photographs portraying hospital activities, and the files are widely used by newspapers, magazines and different community organizations. In addition to news releases and photographs, the department supplies background material on a wide variety of subjects related to hospitals and hospital services.

Vancouver is served by five radio stations, all of which are interested in hospital activities. With the aid of tape and wire recorders, on-the-spot recordings are made regularly at the hospital. Advance public relations consideration of a problem will almost always prevent it from developing into an emergency. Timing, too, is all important in public relations. Many a battle for public favor has been lost because too little information was given too late. When the public relations department is completely informed from the inception of a policy, it is in a position to move quickly and intelligently if that policy becomes a matter of public interest.

In developing and maintaining its press relations, the Vancouver General Hospital has adhered to one principle—it is essential to be frank with the press. Hospitals should try not to hide anything, and should always try to play fair.

MEDICAL RELATIONS

Communications between the hospital and its medical staff was considered next. Medical cooperation in the hospital's public relations program was immediately forthcoming. Two members of the medical board were named as liaison officers between the doctors and the public relations director, and, through them, accurate and up-to-date medical information is available when required.

In February 1951 the Vancouver General Hospital started publication of a monthly newsletter to the 700 members of its medical staff. Written in a friendly and informal manner, the newsletter, known as the *Spotlight*, reports on appointments to the medical staff and other newsworthy activities of the hospital. Format of the *Spotlight* is pleasing, and the typeface is easily read. A different color is used for the masthead each month, often in keeping with the season. Cost of the project is nominal and the publication is more than achieving its purpose, which is to keep doctors informed about their hospital.

EMPLOYEE RELATIONS

There was a need for improved communications in the field of employee relations. As in any large hospital, business or industry, the unofficial grapevine at the Vancouver General Hospital was a major news channel. As is usually the case, however, most grapevine news was distorted and misleading. This, of course, was not conducive to improved employee relations.

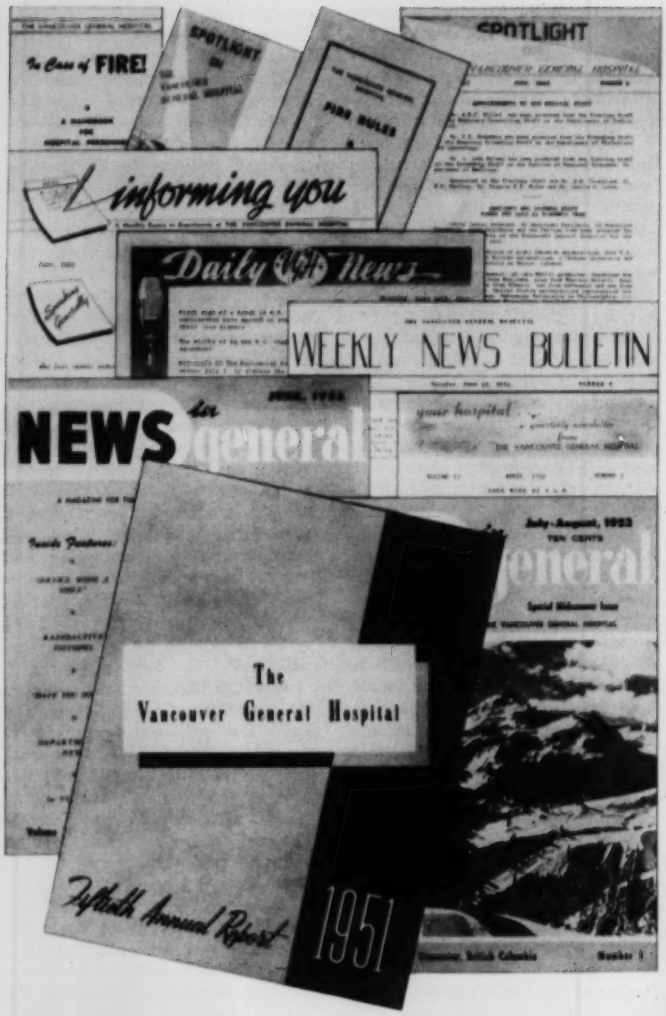
While major public relations projects for employees were still in the planning stage, it was decided to temporarily issue a *Weekly News Bulletin* to all departments and nursing stations, for posting on bulletin boards.

The planning of employee communications is a major undertaking. Many hours were devoted to this phase of the public relations program. Research was carried out, surveys were made, effectiveness of suggested projects was tested. By the end of its first year of a planned public relations program the hospital could point to several projects designed to improve employee relations, each project tailor made to meet a specific need.

First of these projects was a pocket-size handbook containing the names, positions, home addresses and telephone numbers of all key personnel, listed by departments or services. Minor, perhaps, but it resulted in the saving of time and effort.

When the hospital embarked on its public relations program, the need was apparent for a central source of general information concerning the purposes and activities of the more than 40 departments within the hospital, and the institutional agencies and governmental divisions adjacent to, but not part of, the hospital. It was felt that an outline of significant and interesting facts about each department and service would be of considerable interest and value. Department heads prepared the initial 300-word outlines. These were edited and included in a 90-page loose-leaf handbook for ready reference. *The Handbook of Departmental Activities*, printed entirely by the hospital's printing department, is used in many ways, and, from a public relations standpoint, it is a valuable source of material for interpretive feature articles for newspapers, magazines and other publications. It is of value in the hospital's various educational programs.

When publication of the temporary *Weekly News Bulletin* was discontinued, it was immediately succeeded by a monthly newsletter to departments and a monthly



magazine for employees. The newsletter, *Informing You*, is widely circulated to all department heads and their assistants, nursing supervisors and their assistants. It is attractively designed and printed in two colors. Its contents are divided into three sections, Speaking Generally, Your Hospital at Work and Preview Notes. The newsletter is punched for loose-leaf filing, and recipients are requested to share pertinent material with their staffs, and to submit material for publication—adhering to a deadline.

The Vancouver General Hospital's magazine for employees was many months in the planning stage. But, when the first issue was published and distributed, the immediate response of pleasure and satisfaction on the part of employees more than compensated for the many overtime hours spent in planning the magazine.

To stir up interest there were contests, meetings and publicity stunts. The name chosen by the judges—and submitted by two employees, in different departments—was *News in General*. The magazine is printed on slick paper, by the offset lithography process, and emphasizes pictures. It is considered one of the leading employee magazines in British Columbia. It has a wide circulation both inside and outside the hospital, and the cost of its publication is shared by the employees through a voluntary subscription rate.

Assistance in the preparation and revision of handbooks and manuals for employees is another function of the public relations department of the hospital. This assistance includes reading and editing material, suggesting layout designs and publication advice. The public relations director acts in an advisory capacity to the editor and staff of the nurses' yearbook, and assists in the preparation of announcements and advertisements.

PATIENTS AND VISITORS

The most important of any hospital's various publics are its patients. Their impressions are gained from first hand experience. And those impressions must be favorable. Unfavorable patient impressions may stem from unfavorable employee attitudes, inadequate service, or from misunderstanding through lack of information. It is to every hospital's advantage to tell its patients about itself and its services, at the same time explaining and justifying the high cost of modern hospital care.

With visitors, attention must be paid to explaining the need for hospital rules and regulations, especially those regarding smoking, visiting hours and children. If the approach is friendly and the explanations reasonable, it does not take much telling to explain rules and regulations to the satisfaction of all concerned.

A copy of *Serving You*, the hospital's completely revised and rewritten information booklet for patients and visitors, is given to every patient on admission, and is available to visitors. Special emphasis is placed on visiting hours, therapeutic diets, the questions asked by the admitting officer, and the reason why hospital costs seem high—but really are not.

Another new public relations project was the preparation of pocket-size cards for visitors.

(Continued on page 88)

EDITORIALS

Aim of the American Hospital Association: To promote the public welfare through the development of better hospital care for all the people.

Getting those tax dollars

WITH ONLY TWO MONTHS left of 1952, there is no time like the present to really go to work and take advantage of the liberalized federal income tax policy regarding contributions to nonprofit hospitals. The federal government now permits individual contributors to nonprofit hospitals to give up to 20 per cent of their adjusted gross income, deduct the full amount given, *and pay no tax on that amount.*

For instance, a single person with an adjusted gross income of $30,000 can give $6,000 to a nonprofit hospital at a net cost of only $2,000, realizing $4,000 in tax savings as a result of the gift.

The new pamphlet, "Giving for Less" (now brought up to date after liberalization of the tax laws), shows tax savings available to individuals, married couples and corporations because of contributions to hospitals.

It is not uncommon, in the waning months of a year, to find individuals and corporations almost anxious to give money away before December 31 in order to reduce the amount they must pay in taxes. If someone shows them how they can do this and at the same time make a significant contribution to the health and well being of their community, the selling job should be easy. To a corporation, the public relations value of such a contribution should be obvious. But this cannot be put off. The time to sell this idea is now. Next month may be too late.

A healthy interest

EVEN THE OPTIMISTS were astonished by the number of people who attended the Association's 1952 convention in Philadelphia. More than 12,000 were registered, and this exceeds by 40 per cent the previous record set last year in St. Louis.

Already plans are being made for the 1953 convention in San Francisco, and the enthusiastic reaction to the Philadelphia meeting certainly provides a cue for 1953. This year's program, built around the principle of group participation, brought capacity crowds to every general session.

While this response reflects favorably upon the nature of the program, it is also a clear indication of the ever growing interest that hospital people have in their field and in their national association. They attended the convention for many reasons, but the primary reason was to learn. The desire to learn, to share knowledge and experiences, and to progress with the times—this is the factor that has brought hospital care in North America to its present high level, and it is this desire that keeps an association healthy.

Pantry maids are human

PROBLEMS OF HUMAN relations—intra-group friction, desire for status—were provoking high turnover and absenteeism among the pantry maids at St. Vincent's Hospital, New York City. The remedy for this situation, as described by Sister Miriam Eveline on page 107, embodies one of the most outstanding employee training programs yet to be reported by a hospital.

The problems led hospital authorities to a voluntary training program which treated pantry maids as ordinary human beings who want to make a good appearance, solve emotional problems with reasonable satisfaction, and know the value of themselves as individuals. In a series of 11 lectures and demonstrations, the first seven meetings were on these foundations for healthy human relations.

The remaining four lectures covered the evolution and theory of hospital food service. A follow-up course on nutrition and diet therapy is being offered this fall.

Still meeting problems head-on, and solving them, the hospital changed the job title from pantry maid to food service aide—because its serving girls had looked longingly and with admiration at the nurse aides.

Training programs which visualize the worker as more than an animated job description have been used successfully by industry. Hospitals have not often approached their employees with this sophisticated point of view. The amazing results realized by Sister Miriam Eveline are an indication that, used with discretion, this new approach to personnel is profitable.

Resignations among pantry maids dropped 82 per cent; absenteeism dropped 69 per cent.

The St. Vincent's Hospital program could be applied with little adaptation to any department of any hospital. With such results, more training might well be initiated before an acute situation develops.

Volunteers succeed with fulltime shop

FOR ALMOST TWO YEARS now, the Gift and Coffee Shop of Mercy Hospital in Charlotte, N. C., has been open nine hours a day, six days a week for the benefit of patients and visitors to the hospital.

The shop has been a success from the day it opened—Nov. 27, 1950. It has become an oasis of good cheer and a morale builder not only for the patients, their families and friends, but also for doctors, nurses and even for the 340 enthusiastic volunteer workers who have made the project a success.

The idea for the shop germinated after the superintendent of the hospital returned from an annual meeting of the American Hospital Association and told members of the Mercy Hospital Guild about the national organization of women's hospital auxiliaries and what other auxiliaries

3 GREAT ADVANCES

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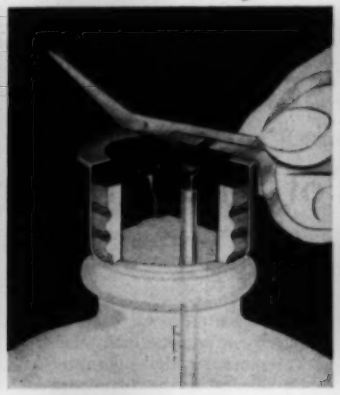

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were doing to help their hospitals.

A chairman was appointed to look into project possibilities and to formulate a plan of operation. The chairman visited several hospitals operating gift and coffee shops and wrote letters to many others. From her findings, she drew up plans for a gift and coffee shop.

Since the original guild had too few members to operate a shop daily, an intensive recruitment campaign for more volunteers was begun. Out of the large number that responded, 10 supervisors were chosen. Each of these supervisors has responsibility for the shop for one week. It is her job to see that all workers come as scheduled. To assist her in this, another supervisor notifies each lady by postal card one week before she is scheduled to work. If the volunteer is unable to report, she arranges to swap time with another worker. If she cannot do this, she contacts the supervisor, who selects a worker from the substitute list. This list is made up of persons who are waiting for a permanent place in the program or who are willing to fill in whenever they are needed. The volunteers have remained enthusiastic about the project because they work only when they have the time. None of them serves in the shop more than three hours a month.

A buyer, bookkeeper and treasurer arrange for supplies and handle the financial side of the coffee shop. The gift shop has two buyers, who also serve as displayers, and a bookkeeper and treasurer on the volunteer staff.

For patients who are unable to come to the gift and coffee shop, the "Mary Jo Cart" goes to them with candy, gum, magazines, razor-blades, cosmetics and other items they may need during their stay at the hospital. The cart is an operation separate from the Gift and Coffee Shop. Its volunteer staff is composed of a chairman and 60 volunteers who take turns pushing the cart on its rounds twice daily.

The 340 members of the guild who are working on the project at Mercy Hospital are not doing it just to raise money. They look upon their work as a service to others and believe a word of cheer or consolation gives patients an important lift.

All profits from the shop and the cart are used to help pay for new equipment in the hospital's x-ray department. Last year, the guild presented the hospital with a check for $3,500. The records so far indicate that the guild probably will be able to make a much larger contribution to the hospital this year.

COMMUNITY SERVICE——

Philosophy of a hospital emergency room

VERONICA F. MILLER

AN EMERGENCY first aid service in a 100-bed hospital in a metropolitan area involves considerable responsibility on the part of hospital management and the medical staff in order to make it an effective community service.

Henrotin Hospital, in a densely populated section of Chicago composed largely of residents in the lower income group, maintains an emergency room which is staffed with nurses and interns around the clock. During a 15-year period, the number of persons seeking emergency aid has increased from 2,000 to 7,000 annually.

As a result of this increasing number, it has been necessary to augment the personnel and adopt certain rules and procedures to insure prompt and courteous service by the department. Such service is a most essential factor if an emergency room is to be maintained.

Foremost in the operation of such service is the teamwork of the medical staff, which has contributed generously in giving service as well as assisting in ways and means of organization. A monthly rotating service was organized wherein all departments of medicine participate, thereby providing the hospital with 24-hour emergency service.

Senior staff members are responsible for all medical treatment and supervise the work of the resident staff. In the absence of a senior staff member, his associate or assistant is put on call, thus assuring the hospital of day and night coverage. For the convenience of staff members, the schedule of rotation is posted six months in advance.

A good nursing service is of the utmost importance. The nursing personnel of the emergency room consists of a nurse-in-charge, three graduate nurses, one orderly and one student nurse. A complete outline of rules, regulations and procedures is kept on file in the nursing office.

The keeping of records, while time consuming, is extremely important. Reports of all cases are kept in triplicate. One copy is filed in the medical records department, one in the accounting office, and the third is filed in the emergency department for reference. The medical record department receives many calls for detailed information, as well as subpoenas to appear in court for the verification of records. No information is released without the patient's written consent.

The number of accident and first aid cases range from 15 to 40

Miss Miller is superintendent of Henrotin Hospital, Chicago.

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daily. The department also takes care of other outpatient services, such as revisit treatment cases, which makes the departmental daily average approximately 65 patients.

HOSPITALIZATION

The disposition of ambulatory cases poses no special problems. Patients requiring hospitalization, however, entail much more consideration. All patients suffering loss of consciousness, shock, or whose lives may be endangered by transferral are hospitalized at Henrotin regardless of circumstances. Fifty to sixty patients a month are transferred to the Cook County Hospital after first aid is given, and 20 to 25 patients a month are transferred to other hospitals because of preference for their family doctors, or on the insistence of the insurance company. The present compensation laws indicate that the employer is not liable unless the employee accepts medical care provided by the insured.

Patients transferred to Cook County Hospital are taken by police ambulance. A detailed report of diagnosis and treatment accompanies each patient for information and guidance of future care. While the police ambulances are not equipped with all the comforts and conveniences of private ambulances, the police give excellent service and follow instructions carefully. They are prompt in responding to calls, in helping to notify relatives, or in accompanying patients to their homes.

ACCIDENT CAUSES

There is no way to predict when the greatest number of accidents may occur. It has been noted over a period of years, however, that the largest number of minor accidents, such as occur in underprivileged and congested areas, happen on Friday, Saturday and Sunday nights. The weather—rain, darkness, sleet and snow—is also a contributing factor in producing accidents. In addition, faulty pavement, congested traffic, overcrowded and poor housing conditions, and apparent lack of proper recreational facilities are among other factors.

Accidents involving a large number of people happen infrequently. The most Henrotin has been called upon to care for at one time were 56 victims of a fire. In this instance, volunteers from all sources were readily available. It seems that people are quick to respond sympathetically in time of great disaster.

Location and space for the emergency department in a hospital are of prime importance. The time element in emergency treatment is a major psychological factor. The department at Henrotin Hospital is adjacent to the ambulance entrance near the street and also next to the x-ray department. There is no greater satisfaction to any patient who has been injured in an accident than to be x-rayed and positively assured there are no fractures. Both doctors and patients appreciate prompt x-ray service as well as a detailed report of the accident and description of the injuries.

ANALYSIS OF REPORTS

A study of accident reports covering a three-month period revealed a variety of information on a total of 1,646 cases. Since the National Safety Council has been carrying on such a constructive program for a number of years, it is interesting to note the contrast in (1) the number of accidents involving public conveyances—4 per cent—as compared to the number involving private automobiles—8 per cent, and (2) the ratio of one child to two adults injured in the home, whereas outside the home in another group of minor accidents, the ratio was one child to five adults.

Alcoholism was reported in 12 per cent of the cases. It should be pointed out that there was no alcoholism reported in any cases of individual drivers of public or private conveyances. The alarming number of assault and battery cases amounted to 10 per cent. Home accidents totaled 6 per cent; industrial accidents numbered 8 per cent, and icy or faulty pavements caused 5 per cent. No narcotic addicts were reported in this group, probably because of fear of detection, since all such cases are reported to the police.

There is always a tragic note about the cases brought to the hospital under the ominous classification of D.O.A. (dead on arrival). Last year, 182 such victims were brought to be pronounced dead as the law requires. These reports frequently read, "Found dead in bed," "Collapsed on the street," or "Heart attack." The majority of such victims lived in very poor rooming houses and appeared to be without family or friends.

All of the department's employees are cautioned in regard to "ambulance chasers," and all irregularities of such nature are thoroughly investigated and discouraged. In cases of irregularities, the local bar association is cooperative and helpful in regard to inquiries if called upon.

COMMUNITY SERVICE

The maintenance of the department is definitely a community service. Everyone is given necessary attention before collection of charges is made. About 25 per cent of the patients pay at the time of treatment. In other cases, charges are handled in a routine manner. The charges are nominal and do not always cover costs, because it is the policy of the hospital that the emergency department is established as a service to the community.

The over-all philosophy governing the department may be summed up in the following instructions, posted in the hospital:

1. Without regard to race, color, creed or finances, *all* patients are to receive prompt first aid service.
2. *All* patients coming to the emergency room for hospital assistance must be given *immediate* attention *without question.*
3. Any patient in such condition that removal from the hospital will endanger life, shall be admitted to the hospital at once *without questioning as to ability to pay.*
4. *Never assume drunkenness until every other possibility has been excluded.*
5. Henrotin Hospital is a public servant. Our emergency room is open day and night to help all who come in need.

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Activating a dormant public relations program

(Continued from page 80)

Helpful hints for visitors are listed on one side, with the visiting hours on the other side. The cards and information booklets are available at many points in the hospital.

Hospital days, for the average patient, are dreary days—unless the hospital does something about it. So, in addition to its information booklets for patients, the Vancouver General Hospital provides its patients daily except Sundays and holidays with the news of the day direct from wires of the leading news services.

The *VGH Daily News* is a telegram-size news bulletin distributed to patients with their midday meal tray, giving headline news of local, national and international nature, combined with latest sports scores, the weather forecast and one or two interesting facts about the hospital. The cost of the project is shared with the radio station which supplies the public relations department with the news each morning.

The idea—not original with the hospital—has been adopted by a number of local firms, and adapted for their own use. It is a very popular project.

LIFE AND ANNUAL MEMBERS

Since its incorporation in 1902, the Vancouver General Hospital has issued an annual report to its life and annual members and other representatives of the community. For many years it lacked "eye appeal." Then, in 1949, the format was changed. Pictures, graphs and short reports gave the annual report an abundance of eye appeal. Further changes were made in the report for 1950, published by the public relations department early in 1951. In a province-wide printing competition, it was judged the best annual report printed in British Columbia during 1951. The same report won honorable mention in an international competition. The comprehensiveness and eye appeal of the 1951 annual report, released in April of this year, was praised editorially in the local press.

The *Quarterly Newsletter* of the Vancouver General Hospital, called *Your Hospital*, is published in March, June, September and December. The first issue appeared in September 1951, and the mailing list includes the life and annual members of the hospital, trustees, several hundred community organizations and leaders in virtually every field of endeavor. It is quoted extensively in the press and over the air.

COMMUNITY ORGANIZATIONS

Members of the hospital staff are encouraged to participate in community affairs, and many of the administrative personnel are active in clubs and associations. Speakers are supplied on occasion to service clubs, business and professional organizations, church groups and other associations. Tours are also arranged through the public relations department.

In the course of a year at the Vancouver General Hospital, more than 700,000 pieces of printed matter are prepared, printed and distributed by the public relations department, including copies of the hospital's six periodic publications, manuals, booklets, pamphlets, brochures and cards.

Certainly the success of a public relations program cannot be evaluated alone by the quantity of printed material prepared, but these quantitative figures do give an idea of the emphasis placed on the printed word in the hospital's program.

TOTAL COST

As for the total cost of the program, the public relations department's annual operating expense budget, including all expenses, is less than one-quarter of 1 per cent of the hospital's total budget for 1952. To many businesses and industries, this figure would appear ridiculously low when compared with public relations and advertising budgets of 4 to 5 per cent of the total annual expenditures.

It is extremely difficult, if not impossible, to evaluate a public relations program in dollars and cents. Many aspects of the program cost nothing except time and the expenditure of a little good will. In the final analysis, a planned program of public relations does cost money—but much less than might be expected.

Is this expenditure of time and money justified? It is felt by the Vancouver General Hospital that the public understanding, appreciation and support resulting from its public relations program more than justify the expense.

The administrator and other administrative officials must always have an "open door" so to speak, for the physician. There should not be any formality regarding his contact with the administrative officials at any time and for any reason. Complaints and suggestions should be received pleasantly, courteously, and gratefully and promptly investigated, not forgotten or pigeon-holed. Many of these can be settled in conference at the time or on the spot, so to speak. If not able to reply immediately and more time is needed to give the physician an answer, tell him so and when you will see him again to talk over the matter. Be sure to keep any such appointment. The reply should be in the form of a well-considered statement, free from prejudice one way or another, and should be frank and constructive. Never get mad or excited when a physician comes to you with a complaint. If you lose your temper you will likely lose the confidence and good will of the physician. In deciding any issue give primary consideration to the best interests of the patient, so far as possible.—MALCOLM T. MACEACHERN, M.D.

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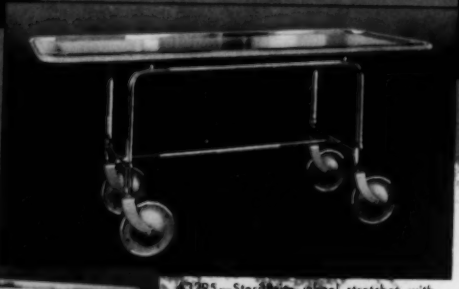

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REFRESHER COURSES—

To reduce the nursing shortage

CONSTANCE BRAMAN, R.N.

DURING THE FALL of 1951, the Massachusetts General Hospital, Boston, planned refresher programs for registered graduate nurses as a means of attracting nurses who were not in active nursing because of marriage or some other factor. As in most other hospitals, the need for nurses was urgent; therefore, every means of providing nursing service had to be utilized.

The Phillips House, the private pavilion of the Massachusetts General Hospital, offered the course, hoping that nurses would remain there or at some other unit of the hospital for six months to a year upon completion of the course.

The supervisor responsible for the in-service program of the Phillips House was assigned as instructor for the course. The head nurses were receptive to the new idea and enthusiastically helped with the program planning. The program was set up with the hope that it would motivate the staff nurse to improve her own nursing technique and stimulate her to self-improvement. The visiting medical staff members generously donated their time to participate in the program, appreciating the opportunity to help in time of need. Publicity for the program was done by the community relations adviser with the help of local newspapers, and radio and television stations.

LETTERS TO ALUMNAE

A letter from the director of the school of nursing and nursing service was sent to every alumna of Massachusetts General Hospital School of Nursing living within commuting distance of the hospital. An application and health record form were enclosed, with a suggestion that if the alumna was not interested, perhaps she had a friend, a graduate registered nurse, who might be available to take the course or come into the hospital to work.

The response was rewarding and interviewing began immediately. During the interview, each candidate's qualifications and previous experience were checked carefully to determine whether she might be advanced later to head nurse or other administrative or teaching positions.

After the nurse had been determined eligible for the course, she filled out an application and was given a form to be completed by her family physician certifying that she was physically fit to do active nursing. If she did not meet the requirements, she was encouraged to continue in her present mode of livelihood.

In order that the program contain instruction applicable to the hospital's situation, an evaluation of the total nursing need was made. It was found that nursing care was needed for medical, orthopedic and surgical patients. The most common types of surgical nursing would include gastric, thoracic, gynecologic and genito-urinary surgery. Since many of the applicants had been out of institutional nursing for several years, review of the fundamental procedures for patient care was advisable.

With the pattern established, the course was organized to include a review of nursing procedures, class instruction and practice in the newer techniques. It was requested that lectures given by visiting medical staff members and directors of related departments emphasize the role the nurse plays in the care of the patient in the specified diseased conditions.

The duration of the tuition-free course was six weeks. The enrollees were instructed six hours, three days a week—Monday, Wednesday and Thursday. These three days were chosen after consulting the adult education centers in Boston. Lockers were provided, but no meals or maintenance was furnished.

The breakdown of hours was as follows:

Doctor's lectures—16 hours
Nursing classes—30 hours
Nursing laboratory—30 hours
Supervised ward practice—26 hours

Six additional hours were planned for greetings, social activities, and a written evaluation by each participant of the course stating benefits received and criticisms.

PROGRAM CONTENT

The program was as follows:

Registration, reception and tour of hospital.
Admission of patient, temperature, pulse, respiration, blood pressure and charting.
Review of bed making and variations of baths.
Foot soaks and Berger exercises.
Pouring and administration of medicines.
X-ray preparations.
Preoperative and postoperative care.

Mrs. Braman is assistant to the general director of Massachusetts General Hospital, Boston.

Types of suction.
Intravenous therapy.
Oxygen therapy.
Enemata (including colostomy).
Catheterization, bladder irrigations and closed bladder drainage.
Abdominal paracentesis, thoacentesis and lumbar puncture.
Eye, ear, nose and throat treatments (tracheotomy tubes).
Discharge of patient.

The lectures by the visiting medical staff and directors of related hospital departments were:

Classes relating especially to the care of the medical patient.
Therapeutic dietetics.
Treatment of gastric ulcers.
Care of diabetic patient.
Treatment of cirrhosis of liver—sprue.
Care of cardiac patient.
Classes relating especially to the care of the surgical patient.
Care of patient with colostomy.
Postoperative care of gynecological patient.
Intravenous therapy.
Blood bank—bone bank.
Postoperative care of thoracic surgery.
Newer trends in surgery.
Anesthesia.
Patient referral plan in the Massachusetts General Hospital.
Research in a general hospital.

DISCUSSION PERIODS

The doctors' lectures, nursing classes and ward practice were correlated whenever possible. Throughout the course, discussion periods were conducted for the purpose of clarification and review. Opportunity was granted to the students for indicating their own particular needs and own interests.

The design of each of the refresher courses has been modified to fit the desires and needs of the students. The students were assigned to ward practice at the discretion of the instructor; however, all material was covered with ample time remaining for ward practice before completion of the course.

The course appeared to be a success, with 53 nurses enrolled. Of these, 10 remained at the hospital as fulltime workers, and 30 remained as part-time workers.

In order to provide better patient care, Massachusetts General Hospital considers its refresher course as a possible solution for securing graduate nurses to staff the hospital adequately, or to return to head nurses, administrative or teaching positions.

1952 survey shows

Hospital rates still rising

HOSPITAL RATES, tied as they are to costs, still show no signs of going down. The sixth annual rate survey conducted by the American Hospital Association shows that room rates in 1952 are approximately 7 per cent higher than in 1951 and 40 per cent higher than in 1947.

Here are some of the pertinent facts revealed by the 1952 rate survey:

Room rates: The average of the most common daily room rates in 1952 in all United States general hospitals were as follows: Single, $12.23; two bed room, $9.68; multi-bed room, $8.24. These rates are about 7 per cent higher than in 1951 and 40 per cent over those in 1947.

Special service charges: Charges for operating rooms, diagnostic tests and therapeutic treatments are gradually increasing, although the most frequent rate has remained fairly constant for the past six years. In 1947, when the first survey was made, 27 per cent of the hospitals charged $20 or more for the use of the operating room for appendectomies. In 1952 this percentage had risen to 65. The number of hospitals charging $15 or more for the use of the operating room for tonsillectomies increased from 9 per cent in 1947 to 31 per cent in 1952.

Anesthesia rates: In the 1952 study, 47.2 per cent of the reporting hospitals stated that charges for anesthesia were established and made directly to the patient by the hospital; 31 per cent by private physicians and 3.3 per cent by other means. The remaining 18.5 per cent did not reply to this question.

Laboratory charges: Hospitals generally show increasing favor to the idea of separate charges on each laboratory test rather than adhering to an all-inclusive rate or a standard charge for routine laboratory tests. More than 60 per cent of the hospitals now have separate charges, as opposed to 48 per cent in 1947.

Newborn: Charging for the care of newborn during the mother's stay is now a reported practice by 85 per cent of the hospitals, an increase from 75 per cent six years ago.

Indigent care rates: Receipts from governmental agencies for care of indigent patients have increased from $5.82 per day in 1947 to $10.93 per day in 1952.

Rates calculated by the Government Reimbursable Cost Formula now average $15.17 per patient day for the country as a whole.

Third-party payments: Data from 1,780 hospitals reporting facts on the percentage of patient days for which some agency assumed all or partial liability indicates that Blue Cross accounts for about 33 per cent of the patient days; commercial insurance, 18.8 per cent; government agencies, 7.8 per cent; and the patients themselves are responsible for the remaining 40.3 per cent.

A booklet containing the complete findings of the rate survey has been sent to Association member hospitals.

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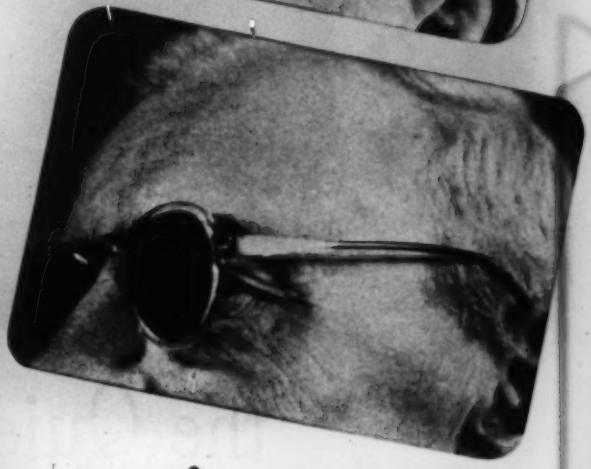

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A sound-absorbing ceiling of Acousti-Celotex Tile instantly checks noise not only in nurseries, but also in wards, private rooms, operating rooms, teaching amphitheatres, kitchens, lobbies and corridors. It brings *quiet comfort* that helps patients rest better, and enables your staff to work better, with less strain, less fatigue.

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Modifying antiquated utility rooms at a minimal cost to the hospital

SIGMUND L. FRIEDMAN, M.D. AND GEORGE V. LASTER

AFTER SEVERAL YEARS of concern over the problems presented by more or less antiquated utility rooms, we have developed some modifications of these rooms which may be of interest to others. The problems which concerned us were, in general:

(1) Many utility rooms built two or three decades ago require modernization which would readily be undertaken by the hospital if it could be done at minimal cost and preferably by the hospital's own maintenance staff, and (2) the typical modern utility room with its fixed cabinets, counters and its tile work makes maintenance difficult and alterations costly.

Specifically, the utility room problems with which the Mount Sinai Hospital of Cleveland was faced when its total modernization program was begun in 1949 were:

1. The utility rooms were of the design approved some 35 years ago.

2. The minor alterations which had been made through the years had actually made conditions worse rather than bettering them.

3. a) There were, first of all, innumerable pipes running horizontally and close to floor level, with others running vertically both in front and behind them. To these were connected the old fashioned clinical sinks, autoclaves, bedpan hoppers, electric sterilizers—and all too frequently, nothing at all.

b) Over the years, shelves of all shapes and sizes had been attached to the walls wherever there seemed to be need and room for them.

c) Rods had been put up for rubber sheeting, rubber tubing and other similar items.

Waste cans and linen hampers stood in the middle of the floor because there was no other place for them. The result was confusion, dirt and those hazards resulting from inability to separate the clean work area from the contaminated area.

These utility rooms could have been modernized readily enough in the usual way but this would have resulted in high initial costs, future maintenance difficulties and an inflexibility which we felt had to be avoided. We therefore designed a room which was built completely by the regular hospital maintenance staff with the exception of the stainless steel plates which were cut to measure by an outside firm.

A "bedpan area" was created by converting an old flower room adjacent to the original utility room. The door of the flower room, which opened into the main corridor, was closed by a wall and a new opening was made into the utility room. The old counters, sink and cupboards in the flower room were removed and replaced by the bedpan hopper, the standard sized cupboards and the usual urinal and bedpan rack attached to the walls.

The clean area was then planned as illustrated. In this clean area, the walls were plastered from ceiling to a height of 4 feet 2 inches from the floor. Below this level the wall remained unplastered and the main lines were permitted to extend beyond the wall. To cover

Dr. Friedman was formerly director of Mount Sinai Hospital, Cleveland, and is now associate medical director of the Health Insurance Plan of Greater New York. Mr. Laster is superintendent of buildings and grounds at Mount Sinai Hospital.

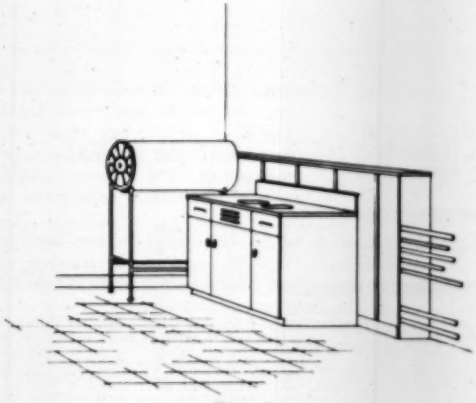


Fig. 1

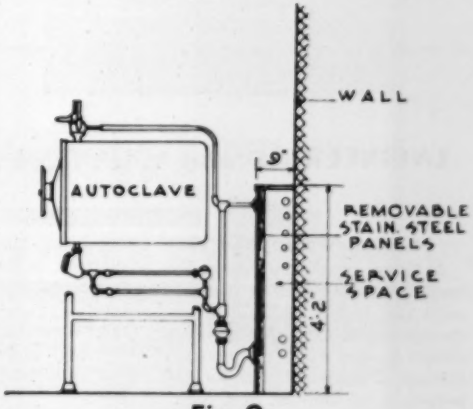
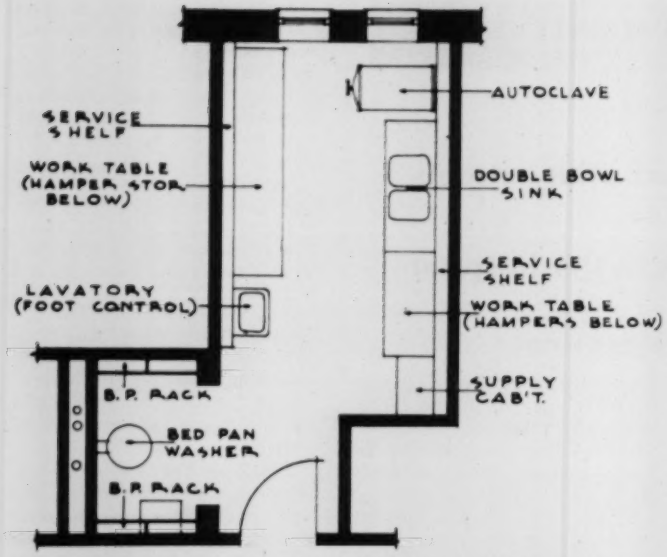


Fig. 2



·REMODELED UTILITY ROOM·
·MT. SINAI·CLEVELAND, O.·'51

them, a stainless steel shelf was devised, as illustrated in the floor plan and in figures 1 and 2. The shelf is 9 inches deep, and from its free edge to the floor, stainless steel plates of identical size were screwed to upright wood supports. The plates were so designed and installed that they are interchangeable and can be readily removed to allow free access to all pipe lines and utilities. They are 44 inches by 24 inches in size and are attached to the two-by-fours by 12 screws. Stainless steel binders or edges are used to secure a tight fit. Hand lavatories, autoclaves and sterilizers were then attached to the main line through these plates.

Counters were also designed so as to be completely interchangeable, readily movable, stand free on the floor, and to accommodate standard sized linen hampers beneath them. Under-counter movable cupboards were designed and installed. Six-foot high cupboards, also freely movable, were built for those areas in which they were needed. A hand lavatory was placed at the exit from the contaminated area, close to the entrance to the clean area. A special water-resistant paint was chosen because it had been proven in use in both the brewery and chemical industries.

The purpose of the stainless steel shelf was a triple one:

1. To permit ready access to the pipe lines.

2. To make for easy shifting of major equipment in accordance with need.

3. To permit such unforeseen changes as may become necessary with time—all at minimum cost.

We believe the first two purposes have been accomplished. For example, an autoclave had to be moved some months after installation; the change was made with very little trouble and at the cost only of the labor involved. We have not bothered to calculate the cost had we done the same operation in a tiled utility room with fixed cabinets and counters—though it is safe to say that we probably would not have done it.

These utility rooms have proven so satisfactory to nurses that six utility rooms have been modernized, using this design with such modifications as necessitated by the space limitations of the original rooms. We now plan to modernize four more rooms in the same way and, as a matter of fact, have written corresponding specifications for two utility rooms designed for new areas.

ENGINEERING and MAINTENANCE COMMENT

New type snow plow

A home type snow plow, the result of three years of development and testing, is now in production (11E-1)*. The plow is unique in that it collects the snow through a screw-action rotor and propels it up and out of a directional chute. It is said it makes impossible the compacting of snow in front of the plow and reduces to a minimum the tendency of the mechanism to freeze in very cold temperatures. Another innovation is a heating device which prevents the carburetor or governor from freezing.

The plow has a 17-inch plowing swath and is powered by a four-cycle engine. It has three point suspension on two disc type steel front wheels and a semipneumatic rear wheel. The spring loaded chute can be shifted from right or left without over adjustment. The height of the cut is from zero to 1¼ inches and can be adjusted so that it will not scrape on sidewalks or gravel driveways.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

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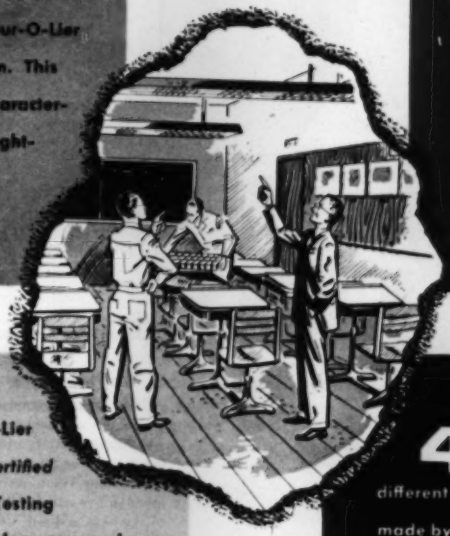

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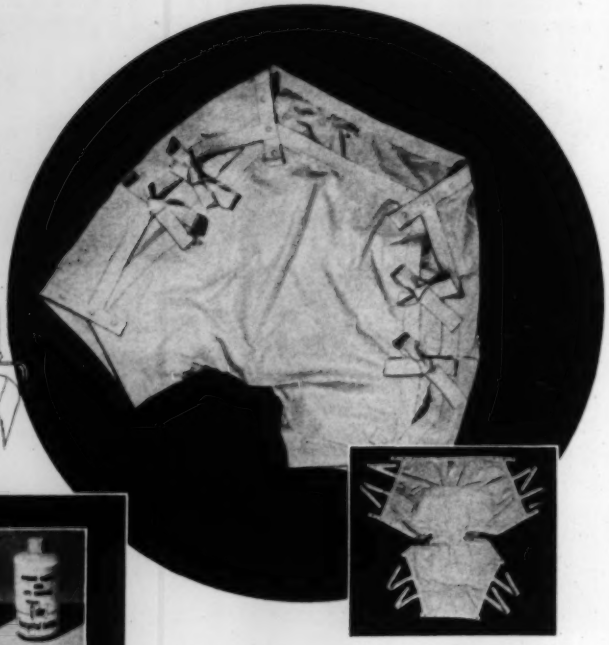

Aloe Hospital Lotion—*More economical, superior to alcohol for body massage*

Now available with label bearing name of hospital

Aloe Hospital Lotion is stimulating, refreshing, and cooling. Contains lanolin, pure olive oil, natural menthol, stearic acid, propylene glycol, magnesium stearate and hexadecanol. Comes in handy 8-ounce bottles or gallon cans from which refills of bottles may be made. Each bottle has a sand-blasted patch for writing patients' names and room numbers. Bottles are packed 3 dozen to a carton.

JS3693A—Aloe Hospital Lotion, 8-ounce bottle, in 3 dozen lots (1 carton), per dozen $3.85
In 12 dozen bottle lots, per dozen 3.45
In 60 dozen bottle lots, per dozen 3.40

JS3693A—Same, but Personalized Label, in minimum lots of 144 dozen bottles, per dozen 3.10

JS3693B—Same, in 1 gallon cans, per can 3.65
In lots of 4 cans, per can 3.55
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In lots of 20 cans, per can 3.25

JS3693C—Plastic Lotion Dispenser, finger-operated pump type; screws on 8-ounce bottle, per dozen 2.20

New Turnalo Garment—*For Involuntary and Incontinent Patients*

Provides ideal protection for ambulatory cases

This recent development for difficult invalid cases is a water- and acid-proof garment designed to be worn by ambulatory or bedridden patients who are involuntary or incontinent. The material is made of Firestone Velon, electronically welded and fashioned in five sizes. Velon is soft and pleasant next to the skin and will not become hard and brittle after repeated use. Pockets front and back are designed to hold cellucotton and therefore supply immediate absorbency. The garment may be laid out flat and the patient rolled onto it. Ties and snaps provide adjustable fitting and required ventilation. Fit in crotch holds the padding in correct position at all times. Because the garment fits smoothly back, front, and sides, it is ideal for ambulatory patients. Easy to clean; may be washed with soap and water. Withstands heat. In ordering, give waist measurement in inches. Available in the following sizes: Junior, 25-31; small, 27-32; medium, 31-37; large, 37-42; extra large, 42-48.

JS3824—New Turnalo Invalid's Garment (please specify size), each $4.25
In lots of 6, each 4.00
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Can pre-packaging of supplies save money for the hospital?

RONALD YAW

TODAY, AS ONE looks around, it is clear that hospitals are about the buildingest things in America. It is no longer necessary at hospital conventions to fuss and stew when you meet someone whose name has slipped your mind. All you need to do is walk up to the familiar face with the missing name and say, "How's your building coming along?" The ice is not only broken, it is pulverized.

And tucked away somewhere in these new buildings is a department that seems to get bigger and shinier with each wave of new hospitals. This is the "Central Supply Department," or more accurately, it may be called the "Central Packaging Department."

As a preliminary, I would like to speculate, for a moment, on how we got this way, what factors led us to the conclusion that we should build acres of stainless steel as the best possible background for many unnecessary procedures.

It is an oversimplification, but we got that way because we formerly had more hands than dollars. We could hire people to do simple repetitive packaging tasks at very low cost. In those pre-Roswell days some of us even thought the student nurse part of supply preparation was free.

We heralded as a great advance every operation that we could centralize. And in fairness, most of it was a great advance. The benefits of central preparation of standard trays, centrally set up for catheterizations, lavages, lumbar punctures, paracentesis trays and related items were many.

The use of standard packs for operating room use, of linen packs, bath packs, and surgical instrument packs is another field in which real advances were made. Incidentally, many of us stopped too soon in this field—there is room for much further progress in this area. For example, in my own hospital, a recent study revealed that we were using seven separately prepared packs and sets for a routine baby delivery. Consequently, 12,000 packages a year were being wrapped and sterilized. By combining a certain number of packs into one package, we saved more than 10,000 packaging operations yearly.

VALUE OF STANDARD PACKS

This pack concept, however, should not be confined to the field of medical supplies. In the business office, admitting office, housekeeping department, laboratory and laundry, related items can be assembled together, and if required, sterilized together.

In the field of the single item (the 4 x 4 sponge, cotton ball, perineal pad, tongue depressor or the cotton tipped applicator), our efficiency also is open to question. We have become the victims of inertia and resistance to change. Yet all that is necessary to experience a profound change is to inspect another hospital. A recent survey disclosed, for example, that the 4 x 4 all-gauze surgical sponge is wrapped in packets of one, three, four, six, ten, twelve, fifteen, twenty and twenty-four in different hospitals. A queer admixture of the British concept of dozens and their multiples and of the American concept of tens and their multiples. Certainly there is no standardization in this item. Yet each hospital hand wraps and sterilizes the packets. About half of the hospitals use the canister technique for packing sponges for dressings, the other half have a myriad of ways of handling dressings. Sponges, however, come from the manufacturer in packets of 100 which no one uses—for anything.

Cotton balls are purchased in thousands, dispensed in threes or fours. In central supply departments, right this minute, people are sitting taking three to four cotton balls out of a box of 4,000 and taking a sanitary pad out of a case of 1,200 and wrapping them by hand into a self-care kit for maternity patients. This particular item accounted for a sixth of a million packages in our central supply department last year.

Tongue depressors are purchased in boxes of 500, and they usually are hand wrapped and sterilized in packs of one or two. Individually-wrapped and sterilized tongue depressors cost an additional 13 cents per 100. Exclusive of wrapping materials, the cost of the hand-wrapping operation exceeds the cost of the item wrapped.

The cotton tipped applicator is still another item. When we buy them now the standard pack is 1,000 and they must all be hand-wrapped and re-sterilized.

The basic trouble is not with the manufacturer. By and large, they can and will supply what we demand. The basic fault is our inattention to our own needs. We have allowed our merchandise to come to us in whatever form or quantity is best suited to the manufacturing and shipping. We need, instead, to reverse the picture and work from the point of use backwards. We would then have a small pre-packaged, pre-sterilized unit sufficient to handle the needs of one patient. Also, these unit packages would come in a bulk container consistent with the needs of a 25-30 bed standard nursing unit.

Perhaps even of greater concern is the actual safety of some of our procedures. There is very real doubt in some circles, for instance,

Mr. Yaw is director of Blodgett Memorial Hospital, Grand Rapids, Mich. He presented this discussion at the American Hospital Association's annual convention in Philadelphia in September.

as to whether or not the dressings in a metal cannister really are sterile. There is even more doubt as to whether a mobile dressing cart, used by a lot of different people, stays sterile.

The material that is used for wrapping hospital supplies is another potential source of danger. Some papers will not allow steam penetration. Some papers allow steam penetration but become brittle and crack open. And some papers cost more than the entire cost of a pre-packaged pre-sterilized item.

A great deal of study has been given to this problem by the Purchasing Committee of the American Hospital Association, with the complete cooperation of one of the leading manufacturers of surgical dressings. The result seems to be that items packaged through commercial sources will be very available in the future.

About four weeks ago, the *Journal of the American Medical Association* published an excellent article which indicated there was some question about the actual sterility of packaged absorbent cotton. Briefly, two well-qualified observers found that about 14 per cent of the samples purchased and marked as sterile were not sterile. It is only fair to the dressing manufacturers to point out that:

1. These were drug store purchases of unidentified brands of one product — absorbent cotton.
2. The controls set up by major manufacturers of surgical dressings are indeed rigid. They urge re-sterilizing whenever there is any room for doubt.

In summary, then, we should carefully review all packaged items prepared in our hospitals to be sure that:

1. We are combining to the maximum degree related items that are used together.

2. We are not paying more in labor costs plus materials than the items can be purchased for in a ready-to-use state.

3. We are alert about adopting existing products and new products as they become available so as to get us out of the hand-packaging business as much as possible.

PURCHASING COMMENT

Color psychology

MANUFACTURERS OF hospital and surgical equipment are gradually coming to realize the psychological value of soft colors on sick patients. The traditional white, symbol of cleanliness and sanitation, or the efficient black and chrome of hospital equipment such as x-ray apparatus and operating room and fracture tables are gradually giving way to other, less impersonal colors, principally pastels.

To the patient who is unfamiliar with hospitals and hospital equipment, the process of undergoing even a simple x-ray examination is a mental ordeal which is rarely relieved by the appearance of the cold, efficient-looking x-ray table. In the same way, the gleaming white glare of the operating room seems to impart an arctic frigidity to the patient who is already cold with fright. Good results have been reported with the pastel shades and it is said that these colors do tend to reassure the patient and put him in a calmer frame of mind.

Color psychology has been known for some considerable time in business and industry and its application to hospital equipment may well herald a new trend in hospital furnishings.

Dictating machine

A dictating and transcribing machine, lighter in weight and smaller in size than any other on the market, is now being produced by an eastern manufacturer (P11-1)*. This transcribing machine weighs 12 pounds and comprises 275 cubic inches, making it almost 25 per cent lighter and 50 per cent smaller, respectively, than any other similar machine.

The machine, which can be carried in a briefcase (See illustration), has many features including a microphone which serves as a speaker, seven-inch "diamond discs" which have a 30-minute dictation capacity, a "4-in-1 control" knob, and it operates on 25 volts of alternating current, or, with a converter, in an automobile or plane.

Asphalt floor tile

A new federal specification for asphalt floor tile, SS-T-306b, based on currently available technical information, has just been released by the General Service Administration, Federal Supply Service. This specification supersedes the older specification SS-T-306a which has been in effect since 1943.

The Asphalt Tile Institute cooperated closely with the government in the test work which resulted in bringing this specification up to date. Copies of the federal specification may be obtained by sending an application to the issuing agency or to the General Service Administration regional office.

The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.

*Readers desiring to know the names of the firm manufacturing the product described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code number that follows the item about which information is requested.

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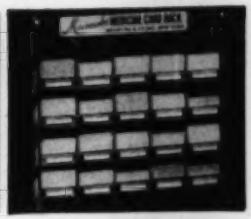

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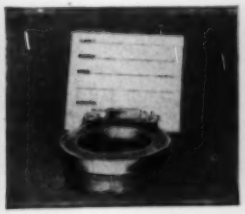
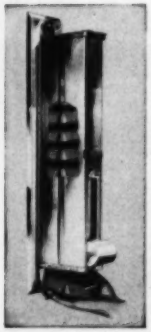


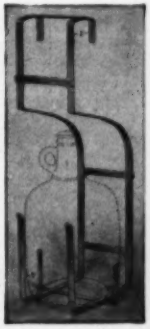
METAL MEDICINE GLASS COVERS —designed with spring clips for holding colored medicine cards, also used as pill trays.

MEDICINE TRAY SETS — These are available in various sizes and styles to facilitate the proper dispensing of medicine.

MORTUARY GOWNS— made of tough cloth paper with full hood attached.—"Perfection" gowns save linen, laundry work and labor.



"STERLING" BRUSH DISPENSER automatically dispenses hand brushes, at same time insuring maximum sterility.



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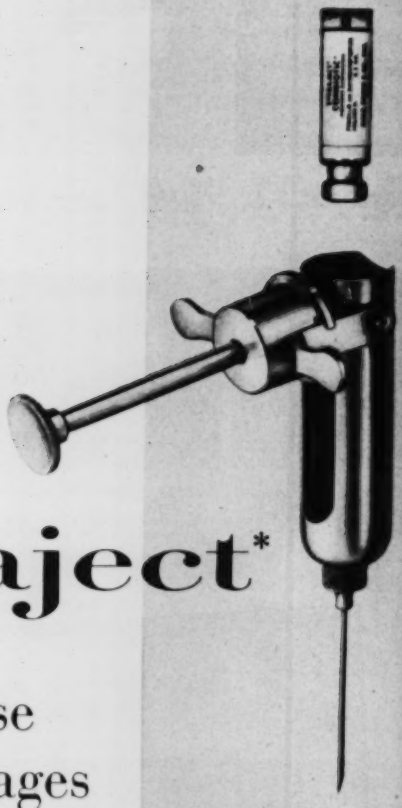

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Silicone oils for lubricating surgical instruments

FRANK W. CROWE, M.D.

SINCE THE APPEARANCE of Sir Joseph Lister's paper "On the Antiseptic Principle in the Practice of Surgery" in 1867,[1] the proper care and maintenance of surgical instruments has been an ever mounting problem.

To achieve bacterial sterility requires vigorous methods—dry heat, live steam under pressure, or strong chemicals. Such sterility is often obtained at the expense of the free action of the instruments due to the destruction of the lubricants normally used. Although the method of sterilization and the quality of surgical instruments have been improved and standardized, little has been done to remove the handicap caused by the rusting and sticking of sterile, but inadequately lubricated, instruments.

A step in the right direction was made when Crowley and Ostrander[2] suggested in 1948 the use of the silicone oils for the sterilization of dental handpieces. This was elaborated on by Barondes, et al[3] in 1950 and has more recently[4] been successfully applied to most surgical instruments.

Although discovered in the early 1930's, the organo-silicon products were not introduced into industry until 1943, and since that time their potentialities appear unlimited. The physical and chemical differences of the silicones and organic compounds are marked; the silicones have a quartz-like skeleton consisting of alternating silicon and oxygen atoms, rather than the carbon-atom framework of the organic compounds.[5] Physical properties[6] are remarkable in that the freezing point is extremely low; the boiling and flash points are high, and there is little change in viscosity between these wide temperature ranges. Volatility is less than 2 per cent after 48 hours at 200°C. (392°F.). These fluids exhibit marked water repellency and surface adhesiveness, and are resistent to oxidation and chemical attack.

Toxicological studies[3,7] reflect their chemical inertness and fail to reveal any significant toxicity. Laboratory test animals have received doses up to 2 per cent of their body weight without discernable effects. No cutaneous sensitization following the therapeutic application of a silicone containing ointment has been observed in 200 or more cases under personal observation.

Despite such desirable physical and chemical properties for an instrument lubricant, it was necessary to determine whether or not the silicone oils would retain their superior lubricating properties after routine sterilization. A nine-month test of a new preparation* containing a mixture of silicone oils has shown the silicones to be far superior to the usual lubricating oils.

All surgical instruments used in the University Hospital operating rooms, in the dermatology outpatient clinic, and in the dermatology clinic of the University of Michigan Student Health Service were lubricated by this silicone oil preparation. The nurses and aids cleaning the instruments, the physicians using them, and the central supply room that was responsible for their care all felt that there was a significant improvement in ease of care and efficiency of the instruments.

The savings in time and money were especially noticeable in the care of the more delicate instruments such as light carriers used in endoscopy; long handled, angulated forceps, and biopsy instruments. Earlier methods of lubrication necessitated maintaining a large reserve stock of these instruments to replace those rusted or locked instruments which had been sent to an instrument shop or returned to the factory to be placed in working order. Such repairs were costly and have proved unnecessary with the use of the silicone lubricant.

The procedure used in caring for all instruments during the nine-month test was as follows:

1. All old, rusted, or corroded instruments were first treated in a rust removing solution, then washed and dried. This step is important in the success of maintaining the older instruments as the silicone fluids are rust inhibitors and lubricants, but will not remove rust already present.

2. A thin coat of the silicone oil preparation was applied with an applicator stick to the entire instrument, making sure that the joints or fulcrum had been coated with the lubricant.

3. A soft cotton flannel rag was used to wipe off the excess of the fluid and to insure even distribution over the instrument.

4. Sterilization.

New instruments were treated in this manner with the silicone fluids as soon as they were obtained. All instruments remained rust-free and showed no signs of corrosion or pitting when this agent was used. Both the old and new instruments showed an increased freedom of action even after the most vigorous sterilization. Cleaning time was appreciably reduced, and the instruments required less frequent oiling.

Another method originally suggested by Crowley and Ostrander[2] and amplified by Barondes[3] uses

Dr. Crowe is a member of the department of dermatology and syphilology, University of Michigan, Ann Arbor.

*Readers desiring to know the name of the firm manufacturing this product should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.

the silicone fluids to lubricate and sterilize in the same operation. In this method the instruments are placed directly in the heated silicone oils after preliminary cleaning and are thoroughly lubricated during the process of sterilization. Crowley and Ostrander noted that bacteria were killed when the oil was held at a temperature of 300°F. for at least 10 minutes. The loss of fluid through carry-out on the instruments is minimal, as pointed out by Barondes, but it is felt that this latter method is more practical in the small office than in a hospital.

The use of silicone oils in the maintenance and care of surgical instruments is indicated by virtue of (1) reduction in time and amount of care, (2) long acting lubrication, (3) increase in the functional life and efficiency of the instruments, and (4) their nontoxicity. It is apparent from the longer instrument life and the reduced labor that a sizable saving in the instrument budget may be expected.

BIBLIOGRAPHY

1. Lister, J.: On the Antiseptic Principles in the Practice of Surgery, Brit. M. J., 2:246, 1867.
2. Crowley, M., and Ostrander, F. D.: Silicone Fluid for Sterilization of Dental Hand Pieces, Science, 108:542, (Nov. 12) 1948.
3. Barondes, R. de R.; Judge, W.D.; Towne, C.G., and Baxter, M.L.: Silicones in Medicine: New Organic Derivatives and Some of Their Unique Properties, M. l. Surgeon, 106:379, (May) 1950.
4. Crowe, F.W.: Use of Silicone Oils in Maintaining Surgical Instruments, J.A.M.A., 149:1464, (Aug. 16) 1952.
5. Wilcock, D.F.: Silicone Oils: Their Properties; General Electric Review, 49:14 (Nov.) 1946.
6. Dow Corning Corporation Bulletin, No. 2001, Midland, Mich., 1948.
7. Rowe, V. K.; Spencer, H.C., and Bass, S.L.: Toxicological Studies on Certain Commercial Silicone and Hydrolyzable Silane Intermediates, J. Indust. Hyg. & Toxicol., 30:332, (Nov.) 1948.

Licensure problems of the foreign medical graduate

ROBERT C. KILLOUGH JR. AND STILES D. EZELL, M.D.

DURING THE 20 years from 1931 to the end of 1951, the State of New York examined 11,300 graduates of foreign medical schools. It is estimated that over 3,000 other physicians were refused admission to the examinations.

With a total of 18,000 foreign graduates examined in the United States for the same period, it is obvious that New York State has assumed the major role in accepting and examining foreign medical graduates. It is also apparent that the great majority of such graduates eventually desire to secure a license in the State of New York.

Correspondence and application records in the files of the New York State Board of Medical Examiners reveal that these foreign graduates are rather generally scattered over the entire United States. It seems advisable to give hospital administrators and chairmen of intern committees comprehensive information which should be advantageous for those foreign graduates who desire to become eligible for the medical examinations in the State of New York. This information is offered in order to avoid undue delays and correct certain false impressions which are encountered daily in the administrative processing of applications made by foreign medical graduates.

Variations in foreign medical education: Prior to World War II European medical education, except in Russia, could be considered basically equivalent to that secured in the United States. Events in Europe, by 1939, had reached a stage where serious interruptions in medical education resulted from new racial laws and enforced military service. Until 1950 the condition of medical education may be described as chaotic. In some areas, medical education has partly recovered from the effects of war, and a number of schools have been approved provisionally by the Regents. However, it is certain that there will be inconsistencies for many years in medical education offered outside the United States.

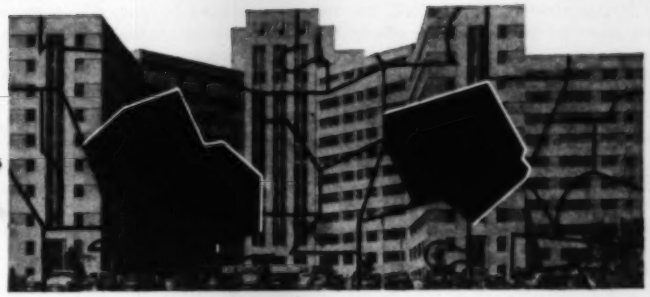
The policy of the Board of Regents: With the great influx of foreign physicians as a result of the war, it was evident that the quality of medical education varied extremely. For a brief time, a few, well-qualified physicians were considered for endorsement without examination; others were admitted administratively to the examinations.

It became apparent, however, that additional training was essential to equalize the education of the foreign graduate. The Regents decided to require two years training in an American medical school, but this was an impossible demand due to overcrowding of all United States medical schools. The plan was modified to allow credit for approved hospital training.

A further modification, now in force, requires all graduates of unapproved foreign medical schools to petition the Board of Regents, and complete one year of approved formal medical study, together with two years of approved hospital training. This plan of formal medical study is designed to provide a thorough and comprehensive review of the whole medical curriculum, and must be taken in New York State.

Problems encountered in this group: Graduates from the period of 1939 to 1950 constitute the major number of applications at present. There is every reason to believe that the number of applications from grad-

Mr. Killough is assistant commissioner for professional education, and Dr. Ezell is secretary, New York State Board of Medical Examiners.



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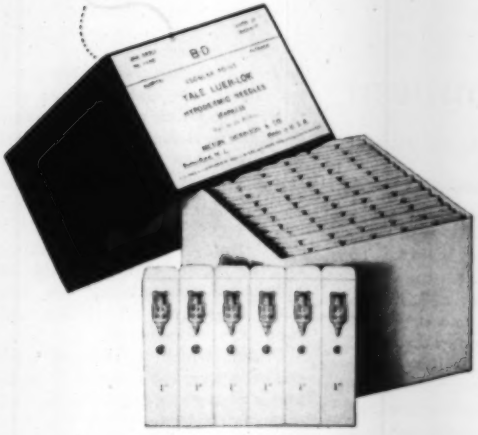

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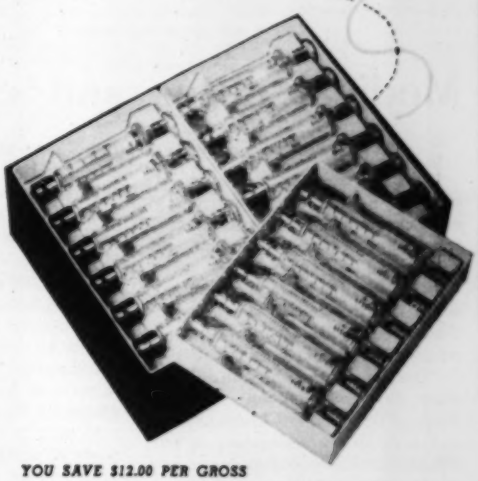

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uates of unapproved foreign medical schools will continue to be somewhere between 500 and 1,000 each year. Whatever the number is to be dealt with, it is our opinion that, in attempting to qualify for licensure, the following are the problems encountered:

1. Failure to realize that the Regents' policy has changed from time to time, as information concerning foreign schools has been communicated to the Regents.

2. Reliance on unofficial information.

3. Internship and residency service in hospitals not approved for such training.

4. Entrance into specialty training programs for diplomate rating before meeting eligibility requirements for state board examinations.

5. The desire to substitute postgraduate courses for the formal study course required by the Regents.

Recommendations: Since a large percentage of all foreign medical graduates desire to be licensed in New York, the following suggestions are offered to hospital administrators and chairmen of intern committees for assisting foreign medical graduates to establish eligibility for admission to the medical licensing examinations in the State of New York:

1. Determine whether applicants have established status with the assistant commissioner for professional education in the State of New York.

2. Inform all applicants of the Regents' policy as it affects the period 1939-1950.

3. Advise all Continental European doctors who graduated between 1939-1950 that their medical education is considered unapproved, except university graduates of Great Britain.

4. Advise all Latin and South American graduates that their education is unapproved, regardless of the time of graduation.

5. Advise all Asiatic graduates, except from the University of the Philippines, that their medical education is unapproved, regardless of the time of graduation.

6. Advise all Russian graduates after 1927, that no consideration will be given to their medical education.

7. Postgraduate work not specifically approved for admission to the examinations in New York will not be credited toward approved formal study as required by the Regents.

8. Inform all foreign graduates of the desirability of securing Regents' action on their own case at an early date after arrival in the United States.

9. Regents' policies in force at the time of petition will apply to all cases on the basis of individual consideration.

It is our opinion that hospital administrators and intern committee chairmen can, by the use of these suggestions, render a definite service to foreign graduates who may be unfamiliar with the policies of the Regents of the University of the State of New York.

Medical notes and comment

Plasma substitutes

Until very recently, civil defense planners have circled the problem of stockpiling blood plasma substitutes for emergency use and offered no specific recommendations. The Federal Civil Defense Administration's *Health Services and Special Weapons Defense*, published in December 1950, reported:

"The use of blood plasma substitutes has not met with general favor in this country. Considerable and favorable investigation of the efficacy of such preparations as osseous gelatin, dextran and polyvinyl pyrrolidone has been carried out but to date they have not received general acceptance by the American medical profession."

Progress has been made in investigating these substances however, and evidence of this fact was an order placed by FCDA recently for a large supply of periston (polyvinyl pyrrolidone) to be stockpiled for disaster use. (See *New England Journal of Medicine* 247:335 August 28, 1952.)

Periston a derivative of acetylene, is particularly advantageous because of its stability, ease of administration and very low cost. The price for 500 cc. is less than $2. It does not require reconstitution as dried plasma does, and it is unaffected by low temperature. Balanced against these positive aspects of periston is the possibility of cell damage if large amounts are used.

Further investigations are being made of periston, but the material as developed to date is the first to fill the minimum requirements of an adequate blood-volume expander.

Research is still going on in the use and manufacture of other plasma substitutes. Gelatin (both osseus and pig-hide) is more expensive than periston but does not tend to be stored in the body or cause cell damage if used in large quantities. Eventually it might supplant periston.

Dextran, as produced domestically by bacterial degradation of beet sugar, and albumin are also more expensive to produce and supplies are inadequate.

Globin, which is retrieved from red cells after the removal of plasma, is both more expensive to produce and less effective in restoring blood pressure than some of the other substitutes.

Although periston has been selected as the most useful of the plasma substitutes, there remain two obstacles to its availability for general use. First is the speed with which the pharmaceutical company commissioned by the FCDA can produce the 1,200,000 units in this initial order. And second, the Food and Drug Administration will have to pass on it before the states are allowed to purchase it.

The Medical Review department is edited by Charles U. Letourneau, M.D., secretary of the Council on Professional Practice.

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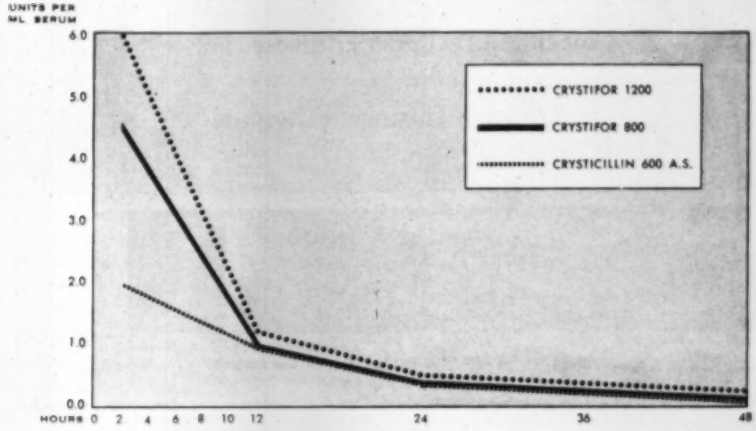

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DICRYSTICIN FORTIS, Squibb Procaine Penicillin G, 300,000 units, plus Potassium Penicillin G, 100,000 units, plus 1 Gm. Dihydrostreptomycin Sulfate, for Aqueous Injection. 1 dose vial. (Dicrysticin Fortis differs from Dicrysticin in that it contains twice the amount of dihydrostreptomycin – 1 Gm. instead of 0.5 Gm.).

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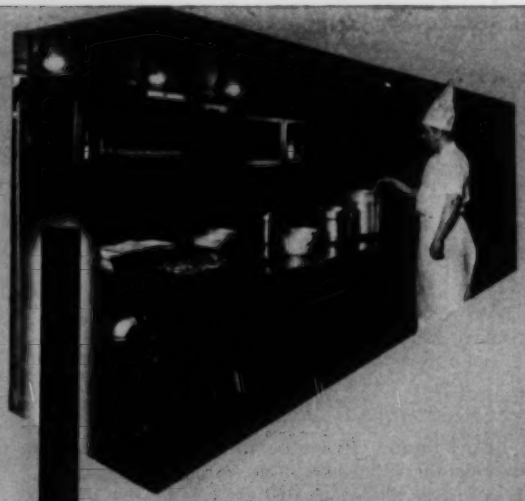

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A HIGH turnover among pantry maids, resulting in constant training of new employees, and money lost by inefficiency, absenteeism and migratory habits is a common challenge to most large nutrition departments. Here at St. Vincent's Hospital of the City of New York we faced the same situation.

We approached the personnel office claiming that we needed higher type employees. The office was unable to secure them. Obviously, therefore, we had to solve our problems with the employees we had.

Of our group of about 75 pantry and serving girls, a survey showed a third had been with us for a period of years and were inclined to hold themselves aloof and superior to newcomers. A smaller group of younger people, more ambitious and with higher I.Q.s, looked with envy at the nurses' aide training course. The third and largest section was our big problem. The majority of this group has a minimum of formal education. Many are still adjusting to American ways of life, have relatively low standards of living, and present a picture of instability and emotional disturbance.

Whatever strategy we used to remedy these problems had to be effective. Our decision was to offer a series of talks to gain the confidence of these three groups and weld them into one. It was not to be just a lecture course on the how and why of hospital tray service, but an appealing program to give, first and foremost, personal uplift and thus develop an interest among employees in their jobs. Our aims were to develop a better understanding of the pantry maid's role in the organization and a realization of the importance of doing work well. We used modern psychology, knowing that all of us are happy when we take pride in ourselves and our work. There is satisfaction in a job well done.

In planning this course, we were not influenced by the usual outline for employee training programs. We defied the commonplace for a flight of the imagination. The program consisted of a series of 11 talks and demonstrations, the first seven of which were titled "YOU —Body, Mind, Soul." Part II of the series was titled "Your Work" and was presented in four lectures by dietitians. The weekly meetings were held from 1:30—2:30 P.M., a time which overlapped working hours only partially.

It should be pointed out that the seven lectures making up Part I of the series are appropriate to workers in any department of the hospital. The entire training program could be adapted easily for presentation in such departments as laundry and housekeeping.

A professional lecturer in adult education was invited for the first three lectures, or "personal presentation clinics."

Lecture 1 on grooming, make-up and hair dos was a constructive appeal to an otherwise human failing —vanity. This lecture was a discussion of personal grooming for health and beauty, giving a check list by which every woman can check her own grooming. A demonstration was made of principles in the use of cosmetics for individual types. Instructions in care of hair for three basic hair types included suggestions for choosing hair styling to fit facial shape and occasion.

Lecture 2 — figure, posture and walking — was instruction and a demonstration on how to achieve and maintain scientifically correct posture. The point was made that good posture is related to physical well being as well as appearance. Corrective and antifatigue exercises were demonstrated in relation to sitting, standing and walking gracefully and comfortably.

Lecture 3 was on clothes and budget. To offset that ever-present danger of spending a week's wages on a dress with eye appeal whether or not it is becoming, we tried to show the value of simple basic dresses, changed into many different costumes by varying accessories.

Discussion centered around the building of a basic wardrobe which would fit one's life, budget, taste and individuality. Line and color, the difference between a fashion and fad, were among the points analyzed.

Lecture 4: We invited a graduate nurse to speak to the group on personal hygiene. This covered soap, water, deodorants, bathing, good nutrition, care of the teeth and skin, and adequate air, rest and exercise.

Lecture 5: We all have known at some time the exhaustion of grappling with a problem, especially if at the end the solution evades us. Emotional energy is the currency of our personality; it is limited and like the paycheck must be budgeted. We asked a psychiatric social worker to speak to our group on mental hygiene.

Lectures 6 and 7: For the last two lectures in Part I a clergyman spoke on the ethics and morals of every-

Sister Miriam Eveline is director of nutrition at St. Vincent's Hospital of the City of New York. This article is adapted from a paper presented at the 1952 convention of the American Hospital Association which won first prize in the "Stretching Your Hospital Dollar" contest.

BOTH the lectures and the awarding of certificates (right) were aimed at personal uplift for the pantry maids.

day living. The purpose of these sessions was to inspire workers with their own dignity as children of God and consequently respect for the dignity of others. "Thou shall love the Lord thy God with thy whole heart, and with thy whole soul, and with thy whole mind. . . . Thou shall love thy neighbor as thyself."

Finally, we came to the second part—Your Work. Here we had four lectures by four dietitians.

Lecture 8: The first was about modern hospital tray service and traced the development in today's hospitals of a distinct department responsible for the purchase, preparation, service and teaching of food. We compared the nutrition department to a pyramid—at the top the director, then the dietitians and at the foundation the other dietary employees. As a pyramid cannot stand on its peak so a department cannot function without the cooperation of all groups.

Lecture 9: The dietitian from the main kitchen spoke about the functioning of the kitchen, how much labor is involved in the preparation of food, and the cost of the vast amounts of food prepared. Since the pantry maid is the last to handle the tray before it reaches the patient she can enhance, spoil or waste the work and money spent in the purchase and preparation of food.

Lecture 10: A Sister dietitian discussed the importance of the patient and the therapeutic value of an attractive tray. Food service is a difficult problem because his tray may be the only thing a patient sees that looks familiar to him. He feels free to talk about the food or object to it in many ways. The doctor's surgery may be successful, the nurses' service flawless; but if proper nourishment is lacking, the patient will be slow to regain good health.

Food must be served well if it is to tempt appetites. Trite but true is the statement, "We eat first with our eyes." This must be remembered especially with sick people. Palatability, attractiveness, size of serving make the difference between a tray that is adequate and one that is appealing, between the science and the art of good nutrition.

The pantry maid's work is to provide care for sick people through food, and the better our service is, the more quickly patients will recover. Also, in her role she is St. Vincent's Hospital, for a patient may forget Mary or Rosalie, but he will remember the hospital's service. The pantry maid is as responsible as the doctor, nurse or dietitian for the memory each patient carries away. She will reap from her life and work at the hospital as much as she puts into it.

Lecture 11: Lastly, a therapeutic dietitian presented with skeletons, charts and pictures a simple anatomical explanation of the digestive tract and the abnormalities which might require modified diets. The importance of serving accurately all the foods prescribed by the dietitian for patients on special diets was stressed. Since the last lecture has been expanded this fall into a second course on "Normal Nutrition and Diet Therapy," we gave only an outline of the subject.

Thirty-one maids who attended at least seven lectures were awarded certificates of attendance signed by the hospital administrator and director of nutrition. At the same time their job titles were changed from pantry maid to food service aide.

As a further demonstration of personal interest, we have been able to secure for our food service aides passes for radio and television broadcasts.

Training has been resumed this fall with a simplified course in "Normal Nutrition and Special Diets." Attendance at this, as for the first training program, is voluntary. Thirty-five employees have registered for the course. At the end we hope to award pins.

Have we realized a 100 per cent improvement in personal appearance, absenteeism, turnover and job satisfaction? No, this is a long range program. Already we have notable improvement in *esprit de corps*. Statistics for resignations, discharges and absenteeism during the same three months of 1951 and

The Dietetics Administration department is edited by Mrs. Isola Denman Robinson, dietetics specialist.

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TOPICS for lectures: Development of modern hospital food service; aids to attractive appearance; the maid's role in patient therapy and the hospital's public relations.

1952 show a decided improvement in our employee relations.

	1951	1952
Resignations	24	4
Discharges	18	12
Days of absenteeism	173	54

We have computed that the cost of replacement and training a new dietary employee is $67.50.

Cost of hiring, physical examination, laboratory and x-ray	$15.00
First week's pay (during training)	27.50
Supervisor's time in training	15.00
Miscellaneous	10.00
Total	$67.50

We believe, therefore, we have saved $1,755 on turnover for three months.

Coverage for absenteeism costs approximately $5 a day, so we have realized $595 in three months, or a total saving of $2,350.

Not to be measured in dollars and cents, however, is the satisfaction of having given an incentive and happiness to others. It is encouraging to receive comments from dietary workers expressed in their own way and often in broken English. "I like fine because I learn more." Or "I want more next year, I like to learn about the special diets." We can't be too discouraged when we hear "I no understand a lot, just a little" because this worker continues coming for "a little."

For us our experiment in employee training has been a satisfactory experience. We feel we have a long way still to go, but we have tangible proof of having stretched the hospital dollar, for we have saved labor, saved time and saved money.

Does the patient like his diet?

ELLEN B. GUERNSEY

THE PERSON who is translating the therapeutic diet order into actual food to be eaten may often need the patience of Job and the wisdom of Socrates. There is no way yet devised which will guarantee amiable acceptance by everyone of an imposed change in eating habits.

Happily, there are always some patients who are so concerned with getting well that they are not overly disturbed by the restrictions imposed by modified diets. They are pleased with their diets either because they feel better already or because they expect the diets will help them feel better soon.

Many patients, however, react differently, and create problems in meeting the third requirement of an ideally planned diet: Its acceptability to the patient. Synchronized human relations with technical knowledge in such instances is not easy.

Personal visits: It may seem elementary to mention personal visits to patients, but since this activity is often pushed aside under pressure of other duties, we venture to speak of it here. Personal visits to patients for the purpose of discussing their diets may be particularly effective in "selling" the diets and in forestalling complaints. Good rapport between patient and dietitian is established when the patient is visited early in the game—if not the day before the diet is in effect, then on the day the diet begins. The advantages are two-way. The patient is pleased to be recognized as an individual and to have a chance to talk about his food habits and preferences. The dietitian knows the patient also as an individual and plans the diet for him and not for an obscure somebody. The diet has a much better chance of acceptance.

An explanation of the content of the diet is helpful. The patient generally likes to know why some foods are omitted and others emphasized. The dietitian has the responsibility of interpreting food and diet to the patient, but questions concerning the relationship between physical condition and diet should be referred to the physician.

Most patients are pleased with the interest shown in them and respond accordingly. Even if they don't honestly like their diets, they accept them in better spirit. The food is eaten more completely, resulting in more adequate nutrition. And complaints tend to be less numerous and intense.

If the diet therapy is to be successful, it frequently must be continued after discharge. This means

Miss Guernsey is senior nutritionist, Division of Medical Services of the New York State Department of Health. This article appeared originally in the Rochester (N. Y.) Regional Hospital Council *Bulletin* for July 11, 1952. Miss Guernsey is a regular contributor to the *Bulletin*, and the author of "Checking Garbage for Pointers on Unnecessary Food Waste" in the July 1952 issue of HOSPITALS.

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two things. First, the patient needs to accept the food regime and understand it thoroughly. It is hoped that this has been accomplished during hospitalization. Second, the person who plans the diet needs to consider the patient's income, his home conditions (such as who will prepare the diet, the cooking facilities and the adaptability of the diet to the family's food habits), his food preferences, and the availability of the foods recommended.

Dietetics Comment

Dietitians and the Association Convention

DIETITIANS from all sections of the country were registered at the American Hospital Association convention in Philadelphia the week of September 15. Hospitals in 20 states were represented.

Dietitian-registrants expressed great interest in the program, the exhibits, and Association services. One of their group, Sister Miriam Eveline, director of nutrition, St. Vincent's Hospital of the City of New York, received first prize in the "Stretching Your Hospital Dollar" contest. Her winning entry appears on the preceding pages of this issue of HOSPITALS. (See "Profitable Results of Employee Training.")

Two other of the 10 contest finalists appearing on the convention program presented ideas which affect the food service. Gerald F. Wagner, assistant administrator of Charles S. Wilson Memorial Hospital, Johnson City, N. Y., told about food vending machines used at his hospital to eliminate late evening food service to staff and employees. Sister Mary Evangeline, administrator of St. Mary's Hospital, Gates Memorial, in Port Arthur, Texas, described a simple procedure for controlling silver in the dietary.

The "Stretching Your Hospital Dollar" contest made its third appearance at the 1952 convention. In all probability there will be another similar contest at the 1953 Association convention, to be held in San Francisco. It would be well worthwhile for dietitians to keep in mind innovations in methods or equipment as possible entries in the 1953 contest.

Plastic wiping towels

The company manufacturing a new variety of plastic wiping towel claims that its product can be wrung dry without damaging the fabric (10D-1)*. The towels are reportedly heavier, thicker, stronger, softer and more absorbent than other brands of plastic towels.

Hospital dietitians may find these useful and economical. One suggestion is to test them out as emergency towels for those weekends or holidays when linen shortages sometimes occur and are a problem.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

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Master Menus for December

THE DECEMBER SERIES of the American Hospital Association's Master Menu is printed on this and the following pages.

These menus reduce to a minimum the number of diets, simplify planning, decrease costs and conserve food preparation time. The general diet forms the basis of the seven most commonly used modified hospital diets. Selections to be served on the general diet are set in boldface type in the Master Menus.

Modified diets in the menu plan are the soft, full liquid, high protein, high calorie, low calorie, low fat and measured or weighed. All execept the full liquid diet have been planned to include the nine food essentials and servings required for nutritional adequacy. The menus are adaptable for selective service. Consideration is given in planning to flavor, variety, attractiveness and general acceptance by patients.

Master Menu kits containing the revised wall cards, sample transfer slips and the "Master Menu Diet Manual" are available to users of the menus. The kits are priced at $2 and may be secured by writing the Editorial Department of HOSPITALS. Single copies of the manual are $1.50.

Full directions for using the Master Menu are in the manual and information on preparing 15 other modified diets with the aid of the menus.

December 1

1. **Fresh grapes**
2. Grapefruit juice
3. **Rolled wheat or puffed rice**
4. **Poached egg**
5. Link sausages
6. **Toast**

7. **Chicken rice soup**
8. **Saltines**
9. **Country fried cubed steak**
10. Broiled cubed steak
11. **Parsley potatoes**
12. Parsley potatoes
13. **Broccoli with lemon butter**
14. Green peas
15. **Tomato aspic ring filled with cole slaw**
16. ———
17. **Orange chiffon pie**
18. Orange chiffon pudding
19. Cherry sponge
20. Unsweetened canned fruit cocktail
21. Limeade

22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Canadian bacon and asparagus on toast with cheese sauce**
25. Welsh rarebit on toast—asparagus
26. Hot cubed beef—asparagus
27. Baked potato
28. ———
29. **Grapefruit and red apple sections salad**
30. **French dressing**
31. **Coconut cup cakes**
32. Applesauce
33. Orange chiffon pudding
34. Unsweetened canned boysenberries
35. Mixed fruit juice
36. **Bread**

December 2

1. **Half grapefruit**
2. Blended citrus juice
3. **Wheat flakes or hominy grits**
4. **Soft cooked egg**
5. Bacon
6. **Coffee cake**

7. **Consomme a la royal**
8. **Melba toast**
9. **Roast loin of pork**
10. Hot sliced turkey
11. **Fluffy mashed potatoes**
12. Whipped potatoes
13. **Brussels sprouts**
14. Julienne carrots
15. **Waldorf salad**
16. **Mayonnaise**
17. **Coffee ice cream**
18. Coffee ice cream
19. Raspberry gelatin
20. Orange and grape cup
21. Grapefruit juice

22. **Tomato juice**
23. ———
24. **Scalloped oysters**
25. Creamed eggs in toast cups
26. Cold sliced lamb
27. Baked potato
28. **Green beans**
29. **Tossed vegetable salad**
30. **Russian dressing**
31. **Fresh fruit cup—lemon cookies**
32. Canned peaches—chocolate angel food
33. Vanilla ice cream
34. Unsweetened canned peaches
35. Beef bouillon
36. **Hot rolls**

December 3

1. **Orange juice**
2. Orange juice
3. **Oatmeal or crisp rice cereal**

A new publication for the hospital dietitian's library

"Readings in Hospital Dietary Administration" is an important compilation of authoritative articles which have appeared in hospital and dietetic journals.

Each of the nine sections of this book covers another phase of dietary department administration: departmental organization; equipment, plans and kitchen-to-patient service; personnel; food service, including therapeutic diets and the pay cafeteria; purchasing; preparation and serving—from "good taste" to food waste; food cost accounting; the teaching responsibilities of the dietitian.

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18 East Division Street **Chicago 10, Illinois**

4. **Scrambled egg**
5. Bacon
6. **Cinnamon toast**

7. **Beef bouillon**
8. **Saltines**
9. **Breaded veal cutlet**
10. Roast loin of veal
11. **Baked noodles au gratin**
12. Riced potatoes
13. Baked acorn squash
14. Baked acorn squash
15. **Spiced beet salad**
16. **French dressing**
17. **Pineapple graham cracker pudding**
18. Cherry sponge
19. Cherry sponge
20. Unsweetened canned bing cherries
21. Blended citrus juice

22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Potato salad—assorted cold cuts**
25. Baked rice and chicken
26. Cold sliced chicken—spiced beet salad
27. Steamed rice (omit on Soft Diet)
28. **Green peas**
29. ———
30. ———
31. **Hot cherry cobbler—thin cream**
32. Sliced banana in pineapple juice
33. Baked custard
34. Fresh pear
35. Apricot nectar
36. **Swedish rye bread**

December 4

1. **Grapefruit juice**
2. Grapefruit juice
3. **Shredded wheat or farina**
4. **Poached egg**
5. Link sausage
6. **Corn muffins**

7. **Chicken noodle soup**
8. **Toasted crackers**
9. **Stuffed rolled shoulder of lamb**
10. Roast lamb
11. **Parsley potatoes**
12. Parsley potatoes
13. **Green Lima beans**
14. Wax beans
15. **Jellied fruit salad**
16. **Mayonnaise**
17. **Chocolate mint sundae**
18. Vanilla ice cream, chocolate sauce
19. Lime ice
20. Unsweetened canned boysenberries
21. Orange juice

22. **Cream of celery soup**
23. **Bread sticks**
24. **Meat balls and spaghetti**
25. Baked beef patties
26. Baked beef patties
27. Spaghetti with tomato puree
28. **Sliced carrots**
29. **Mixed green salad**
30. **Herb French dressing**
31. **Stuffed baked apple**
32. Baked apple without skin
33. Raspberry rennet-custard
34. Unsweetened applesauce
35. Pineapple juice
36. **Bread**

December 5

1. **Bananas**
2. Orange juice
3. **Rolled wheat or corn flakes**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Tomato juice**
8. ———
9. **Broiled halibut steak with parsley butter**
10. Broiled halibut steak
11. **Browned paprika potatoes**
12. Potato balls
13. **Green peas**
14. Green peas
15. **Cabbage and raisin slaw**
16. **Sour cream dressing**
17. **Cranberry cheesecake**
18. Peach floating island
19. Lemon gelatin cubes
20. Fresh pineapple
21. Essence of celery soup

22. **Cream of spinach soup**
23. **Croutons**
24. **Tuna and celery casserole**
25. Scalloped tuna
26. Low fat tuna
27. Baked potato
28. **Asparagus tips**
29. **Grapefruit and avocado salad**
30. **French dressing**
31. **Raspberry sherbet**
32. Raspberry sherbet
33. Raspberry sherbet
34. Unsweetened Royal Anne cherries
35. Apple juice
36. **Hot rolls—cherry preserves**

December 6

1. **Blended citrus juice**
2. Blended citrus juice
3. **Puffed rice or oatmeal**
4. **Soft cooked egg**
5. Bacon
6. **Toast**

7. **Cream of pea soup**
8. **Toast sticks**
9. **Hamburger patties—mushroom gravy**
10. Baked beef patties
11. **Au-gratin potatoes**
12. Riced potatoes
13. **Paprika cauliflower**
14. Sliced beets
15. **Lettuce, spinach, radish salad**
16. **Savory dressing**
17. **Peach cobbler, whipped cream**
18. Baked rice custard
19. Mocha sponge
20. Unsweetened canned peaches
21. Grapefruit juice

22. **Pepper pot soup**
23. **Saltines**
24. **Apple fritters with maple syrup—bacon strips**
25. Crisp bacon
26. Baked veal steak
27. Whipped potatoes
28. **Spinach**
29. **Tossed green salad with tomato wedges**
30. **Vinegar-oil dressing**
31. **Fresh fruit cup**
32. Canned fruit cocktail
33. Chocolate Bavarian
34. Unsweetened canned fruit cocktail
35. Orange juice
36. **Bread**

December 7

1. **Orange halves**
2. Orange juice
3. **Farina or wheat and barley kernels**
4. **Poached egg**
5. Grilled ham
6. **Whole wheat raisin bread toast**

7. **Cranberry and apple juice**
8. ———
9. **Baked chicken**
10. Roast chicken
11. **Parsley potatoes**
12. Parsley potatoes
13. **Broccoli with lemon butter**
14. French green beans
15. **Carrot and raisin salad**
16. **Mayonnaise**
17. **Butter pecan ice cream**
18. Peach half with lemon ice
19. Lemon ice
20. Half grapefruit
21. Beef bouillon

22. **Southern bisque**
23. **Crisp crackers**
24. **Grilled cheese sandwich—pickle chips**
25. Cottage cheese
26. Cottage cheese
27. Stuffed baked potato
28. **Green peas**
29. **Grapefruit and ribier grape salad**
30. **Fruit salad dressing**
31. **Vanilla blanc mange with chocolate sauce**
32. Grape sponge
33. Vanilla blanc mange
34. Unsweetened canned apricots
35. Fruitade
36. ———

December 8

1. **Bananas**
2. Blended citrus juice
3. **Corn flakes or hominy grits**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **French onion soup**
8. **Saltines**
9. **Braised beef roast**
10. Roast beef
11. **Brown rice**
12. Brown rice
13. **Mashed squash**
14. Mashed squash
15. **Head lettuce salad**
16. **Russian dressing**
17. **Chocolate eclair**
18. Chocolate pudding with whipped cream
19. Chocolate rennet-custard
20. Unsweetened canned loganberries
21. Orange juice

22. **Cream of broccoli soup**
23. **Croutons**
24. **Mixed grill—chicken livers, link sausage, grilled sweet potato pineapple ring**
25. Grilled chicken livers
26. Grilled chicken livers
27. Mashed sweet potatoes
28. **Asparagus tips**
29. **Tomato salad**
30. **French dressing**
31. **Chilled pear halves with custard sauce**
32. Canned pears
33. Cherry gelatin with custard sauce
34. Fresh apple
35. Grapefruit juice
36. **Bread**

December 9

1. **Orange juice**
2. Orange juice
3. **Oatmeal or puffed wheat**
4. **Poached egg**
5. Bacon
6. **Hot biscuits—strawberry jam**

7. **Chicken broth with lemon slice**
8. **Whole wheat wafers**
9. **Ham slice**
10. Roast lamb
11. **Scalloped potatoes**
12. Cubed potatoes
13. **Buttered kale or spinach**
14. Chopped spinach
15. **Apricot and stuffed date salad**
16. **Fruit salad dressing**
17. **Cottage pudding with lemon sauce**
18. Cottage pudding with lemon sauce
19. Whipped strawberry gelatin
20. Fresh pear and grape cup
21. Blended citrus juice

22. **Potato chowder**
23. **Saltines**
24. **Salmon croquettes with mushroom sauce**
25. Creamed salmon
26. Cold roast beef
27. Parsley potatoes
28. **Green beans**
29. **Chinese cabbage salad**
30. **Thousand Island dressing**
31. **Pineapple and plum compote**
32. Canned Royal Anne cherries
33. Baked custard
34. Unsweetened canned Royal Anne cherries
35. Mixed fruit juice
36. **Lemon muffins**

December 10

1. **Half grapefruit**
2. Grapefruit juice
3. **Puffed rice or brown granular wheat cereal**
4. **Soft cooked egg**
5. Canadian bacon
6. **Cranberry muffins**

7. **Consomme**
8. **Crisp crackers**
9. **Broiled cubed steak**
10. Broiled cubed steak
11. **Au gratin potatoes**
12. Diced potatoes
13. **Baked breaded eggplant**
14. Latticed beets
15. **Head lettuce salad**
16. **Honey fruit dressing**
17. **Cream cheese, guava jelly, toasted crackers**
18. Cream cheese, guava jelly, toasted crackers
19. Lemon ice
20. Unsweetened canned fruit cocktail
21. Orange juice

22. **French tomato soup**
23. **Melba toast**
24. **Chicken pot pie**
25. Creamed chicken on toast
26. Cold sliced chicken
27. Steamed rice
28. **Asparagus tips**
29. **Celery hearts and radishes**
30. ———
31. **Canned peaches**
32. Canned peaches
33. Chocolate rennet-custard
34. Unsweetened canned peaches
35. Pineapple juice
36. ———

December 11

1. **Blended citrus juice**
2. Blended citrus juice
3. **Hominy grits or wheat and barley kernels**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Broth with julienne vegetables**
8. **Saltines**
9. **Roast leg of veal**
10. Roast leg of veal
11. **Mashed potatoes**
12. Whipped potatoes
13. **Brussels sprouts**
14. Baked acorn squash
15. **Cranberry jewel salad**
16. **Cream mayonnaise**
17. **Pineapple upside down sponge cake**
18. Pineapple whip, custard sauce
19. Pineapple whip
20. Unsweetened canned pineapple
21. Grapefruit juice

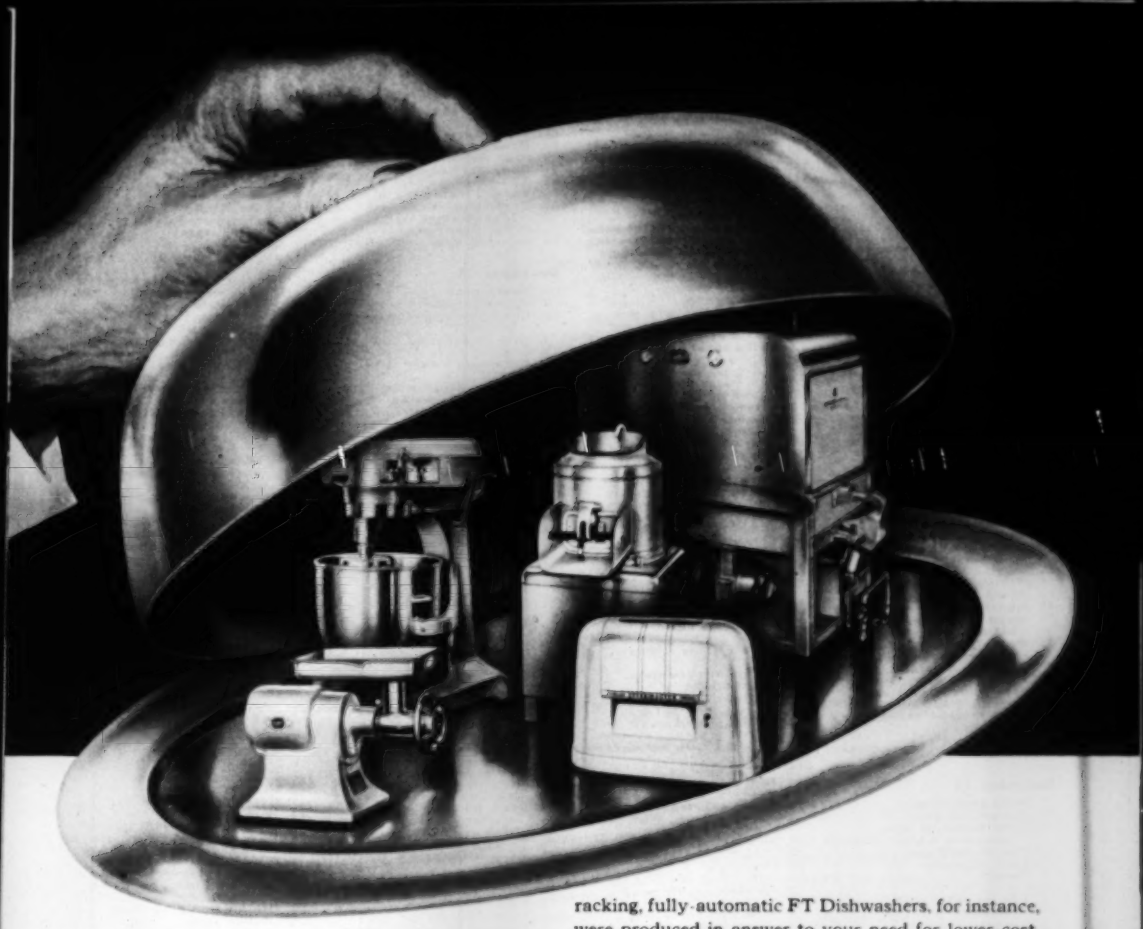
22. **Split pea soup**
23. **Crisp crackers**
24. **Corned beef hash**
25. Scrambled eggs
26. Broiled lamb chop
27. Paprika potato balls
28. **Spinach with lemon wedge**
29. **Cabbage, carrot and green pepper salad**
30. **Sour cream dressing**
31. **Deep dish apple pie a la mode**
32. Apple tapioca
33. Vanilla ice cream
34. Unsweetened canned apricots
35. Tomato juice
36. **Corn bread**

December 12

1. **Fresh grapes**
2. Tomato juice
3. **Tuna flakes or farina**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Cream of celery soup**
8. **Toasted crackers**
9. **Fried oysters—tartar sauce**
10. Baked ocean perch fillets
11. **Potatoes with parsley cream sauce**
12. Parsley potatoes
13. **French green beans**
14. French green beans
15. **Pear salad on watercress**
16. **Harlequin dressing**
17. **Crusty blueberry cobbler**
18. Tinted pear and rice compote
19. Cherry gelatin
20. Unsweetened canned boysenberries
21. Blended citrus juice

22. **Manhattan clam chowder**
23. **Oyster crackers**
24. **Macaroni and cheese casserole**
25. Macaroni and cheese
26. Cottage cheese
27. Baked potato (omit on Soft Diet)
28. **Green peas**
29. **Sliced orange salad**
30. **French dressing**
31. **Gingerbread**
32. Prune whip
33. Baked custard
34. Unsweetened canned prune plums
35. Fruitade



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Hobart *Food Machines*

The World's Largest Manufacturer of Food, Kitchen and Dishwashing Machines

36. **Hard rolls**

December 13

1. **Orange juice**
2. Orange juice
3. **Rolled wheat or crisp rice cereal**
4. **Scrambled egg**
5. Grilled ham
6. **Cinnamon buns**

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7. **Chicken noodle soup**
8. **Saltines**
9. **Braised liver—bacon strips**
10. Baked liver
11. **Stuffed baked potato**
12. Baked potato
13. **Stewed tomatoes**
14. Asparagus tips
15. **Banana rolled in mayonnaise with lemon juice and nuts on watercress**
16. ———
17. **Marble cake with mocha butter cream frosting**
18. Marble cake with mocha butter cream frosting
19. Orange ice
20. Unsweetened canned fruit cocktail
21. Grapefruit juice

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22. **Cream of corn soup**
23. **Cheese crackers**
24. **Sauteed chopped beef sirloin and mushrooms on toast**
25. Broiled beef patties
26. Broiled beef patties
27. Riced potatoes
28. **Quartered carrots**
29. **Head lettuce salad**
30. **Chiffonade dressing**
31. **Peach, banana and walnuts in strawberry gelatin, whipped cream**
32. Peach and banana gelatin
33. Strawberry gelatin with custard sauce
34. Unsweetened canned bing cherries
35. Apple juice
36. **Bread**

December 14

1. **Half grapefruit**
2. Grapefruit juice
3. **Corn flakes or brown granular wheat cereal**
4. **Soft cooked egg**
5. Link sausage
6. **Toast**

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7. **Cherry juice with orange sherbet**
8. ———
9. **Baked smoked ham**
10. Roast lamb
11. **Mashed potatoes**
12. Riced potatoes
13. **Green peas**
14. Green peas
15. **Pineapple and stuffed prune salad**
16. **French dressing**
17. **Lemon chiffon pie**
18. Lemon chiffon pudding
19. Maple sponge
20. Fresh pineapple and orange cup
21. Consomme

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22. **Black bean soup with chopped egg and lemon slice**
23. **Saltines**
24. **Toasted lettuce, sliced chicken, tomato and bacon sandwich**
25. Creamed chicken—latticed beets
26. Cold sliced chicken—latticed beets
27. Fluffy rice
28. ———
29. **Celery hearts**
30. ———
31. **Canned whole apricots**
32. Canned peeled apricots
33. Floating island
34. Unsweetened canned apricots
35. Cranberry and pineapple juice
36. ———

December 15

1. **Tomato juice**
2. Tomato juice
3. **Oatmeal or wheat flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

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7. **Alphabet soup**
8. **Whole wheat wafers**
9. **Baked veal chop—spiced crabapple**
10. Baked veal chop
11. **Noodles au gratin**
12. Noodles
13. **Glazed carrots**
14. Sliced carrots
15. **Romaine and endive salad**
16. **Thousand Island dressing**
17. **Baked Indian pudding, vanilla ice cream**
18. Vanilla ice cream
19. Lemon ice
20. Fresh grapes
21. Orange juice

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22. **Cream of mushroom soup**
23. **Melba toast**
24. **Jelly omelet**
25. Jelly omelet
26. Cold roast lamb
27. Baked potato
28. **Green beans**
29. **Shredded green and red cabbage salad**
30. **Sour cream dressing**
31. **Royal Anne cherries—oatmeal cookies**
32. Royal Anne cherries
33. Baked caramel custard
34. Unsweetened canned Royal Anne cherries
35. Mixed fruit juice
36. **Pecan rolls**

December 16

1. **Bananas**
2. Blended citrus juice
3. **Puffed rice or rolled wheat**
4. **Scrambled egg**
5. Bacon
6. **Bran muffins**

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7. **Cream of corn soup**
8. **Toast sticks**
9. **Grilled chopped steak**
10. Broiled beef patties
11. **Baked potato**
12. Baked potato
13. **Broccoli with hollandaise sauce**
14. Spinach
15. **Iced celery curls**
16. ———
17. **Peach shortcake**
18. Baked custard with sliced peaches
19. Lime gelatin cubes
20. Grapefruit sections
21. Grapefruit juice

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22. **Chicken noodle soup**
23. **Saltines**
24. **Ham and cornbread shortcake**
25. Cottage cheese
26. Cottage cheese
27. Acorn squash
28. **Green peas**
29. **Tomato salad**
30. **French dressing**
31. **Lemon sherbet—cherry sugar cookies**
32. Lemon sherbet
33. Lemon sherbet
34. Unsweetened canned peaches
35. Orange juice
36. **Bread**

December 17

1. **Orange juice**
2. Orange juice
3. **Farina or shredded wheat**
4. **Poached egg**
5. Bacon
6. **Toast**

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7. **Cream of pea soup**
8. **Melba toast**
9. **Chicken loaf**
10. Baked liver
11. **Candied sweet potatoes**
12. Parsley potatoes
13. **Asparagus tips**
14. Asparagus tips
15. **Apple, date and celery salad**
16. **Mayonnaise**
17. **Lattice cherry pie**
18. Vanilla pudding, cherry juice
19. Cherry sponge
20. Unsweetened canned apricots
21. Blended citrus juice

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22. **Beef broth with rice**
23. **Toasted crackers**
24. **Beef stew with vegetables**
25. Beef cubes and noodles
26. Broiled cubed flank steak
27. Noodles (omit on Soft Diet)
28. **Sliced beets**
29. **Head lettuce salad**
30. **Blue cheese dressing**
31. **Glazed baked apple**
32. Applesauce
33. Vanilla pudding
34. Unsweetened canned loganberries
35. Grape juice
36. **Oatmeal rolls**

December 18

1. **Fresh pear**
2. Pineapple juice
3. **Crisp rice cereal or rolled wheat**
4. **Soft cooked egg**
5. Link sausage
6. **Cranberry coffee cake**

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7. **Chicken broth with chopped parsley**
8. **Saltines**
9. **Roast top sirloin of beef**
10. Roast beef
11. **Oven browned potatoes**
12. Riced potatoes
13. **Cauliflower with cheese sauce**
14. Julienne carrots
15. **Gingerale fruit gelatin salad**
16. **Cream mayonnaise**
17. **Peppermint stick ice cream**
18. Peppermint stick ice cream
19. Lemon ice
20. Unsweetened canned fruit cocktail
21. Orange juice

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22. **Split pea soup**
23. **Crisp crackers**
24. **Blueberry pancakes with maple syrup—bacon**
25. Baked lamb patties—broiled peach half
26. Baked lamb patties
27. Potato balls
28. **Chopped spinach**
29. **Grapefruit and red apple section salad**
30. **Fruit salad dressing**
31. **Lemon meringue pie**
32. Snow pudding with orange sections
33. Snow pudding with custard sauce
34. Fresh grapes
35. Tomato juice
36. ———

December 19

1. **Grapefruit juice**
2. Grapefruit juice
3. **Oatmeal or puffed wheat**
4. **Scrambled egg**
5. Bacon
6. **Toast**

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7. **Cream of tomato soup**
8. **Croutons**
9. **Salmon loaf**
10. Baked flounder
11. **Scalloped potatoes**
12. Cubed potatoes
13. **Green peas**
14. Green peas
15. **Cabbage, pineapple and marshmallow salad**
16. **Mayonnaise**
17. **Chocolate coconut layer cake**
18. Canned pears—chocolate cake squares
19. Cherry and lime gelatin cubes
20. Unsweetened canned apricots
21. Blended citrus juice

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22. **Julienne vegetable soup**
23. Crisp crackers
24. **Egg cutlet, pimiento cream sauce**
25. Plain omelet
26. Plain omelet
27. Baked potato
28. **Green beans**
29. **Orange and grape salad**
30. **French dressing**
31. **Raspberry sherbet—vanilla wafers**
32. Raspberry ice
33. Raspberry sherbet
34. Unsweetened canned boysenberries
35. Pineapple juice
36. **Potato rusks**

December 20

1. **Sliced oranges**
2. Orange juice
3. **Wheat and barley kernels or farina**
4. **Soft cooked egg**
5. Canadian bacon
6. **Honey raisin buns**

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7. **Beef noodle soup**
8. **Cheese sticks**
9. **Swiss steak**
10. Broiled cubed flank steak
11. **Baked potato**
12. Baked potato
13. **Zucchini squash**
14. Asparagus tips
15. **Apricot and raisin salad**
16. **French dressing**
17. **Prune whip**
18. Prune whip
19. Grape sponge
20. Unsweetened canned prune plums
21. Grapefruit juice

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22. **Old-fashion potato soup**
23. **Saltines**
24. **Veal turnovers with gravy**
25. Creamed diced veal
26. Baked veal patties
27. Whipped potatoes
28. **Sliced carrots**
29. **Asparagus and pimiento salad**
30. **Tarragon French dressing**
31. **Baked apple**
32. Baked apple without skin
33. Vanilla blanc mange
34. Unsweetened applesauce
35. Cranberry juice
36. **Bread**

December 21

1. **Blended citrus juice**
2. Blended citrus juice
3. **Brown granular wheat cereal or puffed rice**
4. Poached egg (omit on Normal Diet)
5. Bacon
6. **French toast—jelly**

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7. **Consomme**
8. **Whole wheat wafers**
9. **Roast rib of beef**
10. Roast rib of beef
11. **Parsley potatoes**
12. Parsley potatoes
13. **Green Lima beans**
14. Wax beans
15. **Banana-nut salad**
16. **Mayonnaise**
17. **Lime sherbet—corn flake macaroons**
18. Lime sherbet—corn flake macaroons
19. Lime ice
20. Orange and grape cup
21. Orange juice

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22. **Cream of asparagus soup**
23. **Croutons**
24. **Scrambled eggs with mushrooms—link sausage**
25. Scrambled eggs
26. Cottage cheese
27. Stuffed baked potato
28. **Green peas**
29. **Toasted salad with tomato wedges**
30. **Vinegar-oil dressing**
31. **Fresh pineapple**
32. Diced pear in raspberry gelatin
33. Raspberry gelatin
34. Fresh pineapple
35. Grapefruit juice
36. **Bran, honey and nut muffins**

December 22

1. **Half grapefruit**
2. Grapefruit juice
3. **Corn flakes or rolled wheat**
4. **Soft cooked egg**
5. Grilled ham
6. **Toast**

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7. **Vegetable soup**
8. **Crisp crackers**
9. **Ham loaf**
10. Roast veal
11. **Au gratin potatoes**
12. Cubed potatoes
13. **Spinach with lemon**
14. Spinach with lemon
15. **Pear and grape salad**
16. **Cream mayonnaise**
17. **Blueberry pie**
18. Baked custard with jelly
19. Pineapple whip
20. Unsweetened canned loganberries
21. Orange juice

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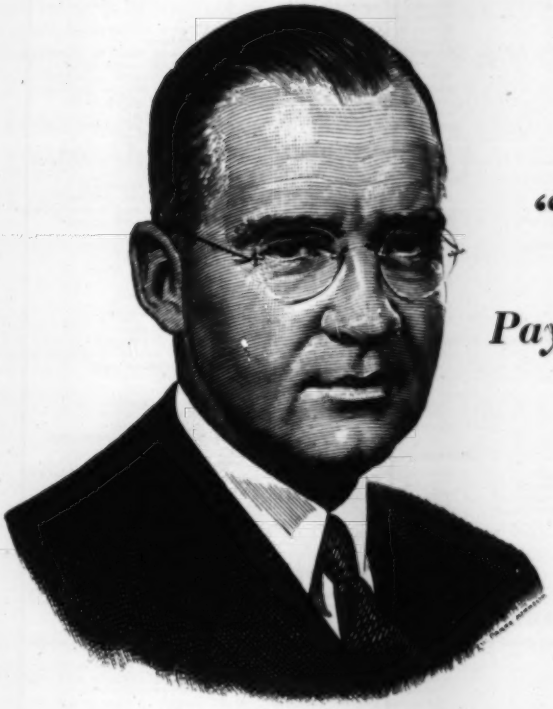
22. **Corn chowder supreme**



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M. B. FOLSOM
Treasurer, Eastman Kodak Company

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- since January 1, 1951, enrollment in The Plan has increased from 5,000,000 to 7,500,000.
- in some companies, more than 90% of the employees are systematic bond buyers—in literally thousands of other companies, employee participation runs 60%, 70%, 80%.
- payroll savers are putting aside $150,000,000 per month in U.S. Defense Bonds.
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23. **Crisp crackers**
24. **Tomato aspic ring with cabbage carrot salad—toasted cheese sandwiches**
25. Broiled lamb pattie—carrots
26. Broiled lamb pattie—carrots
27. Baked potatoes
28. ———
29. **Celery Hearts**
30. ———
31. **Fruity rice pudding, chilled custard sauce**
32. Canned fruit cup
33. Cherry gelatin
34. Unsweetened fruit cup
35. Mixed fruit juice
36. ———

December 23

1. **Fresh grapes**
2. Blended citrus juice
3. **Oatmeal or wheat flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Tomato rice soup**
8. **Toast sticks**
9. **Braised beef roast**
10. Roast beef
11. **Pimiento potato souffle**
12. Riced potatoes
13. **Scalloped eggplant**
14. Mashed squash
15. **Perfection salad**
16. **Mayonnaise**
17. **Frozen peach sundae**
18. Frozen peach sundae
19. Whipped strawberry gelatin
20. Unsweetened canned Royal Anne cherries
21. Grapefruit juice

22. **Potage printanier**
23. **Saltines**
24. **Chicken and noodle casserole**
25. Baked chicken and noodles
26. Cold roast lamb
27. Baked noodles (omit on Soft Diet)
28. **Green peas**
29. **Sliced orange and watercress salad**
30. **Pimiento French dressing**
31. **Cream puffs**
32. Cherry sponge
33. Cherry sponge
34. Fresh pear
35. Grape juice
36. **Bread**

December 24

1. **Tangerines**
2. Grapefruit juice
3. **Bran flakes or hominy grits**
4. **Scrambled egg**
5. Link sausage
6. **Cinnamon breakfast muffins**

7. **Beef bouillon**
8. **Bread sticks**
9. **Braised liver**
10. Baked liver
11. **Stuffed baked potato**
12. Stuffed baked potato
13. **Creamed onions or carrots**
14. Sliced carrots
15. **Tomato and green pepper ring salad**
16. **French dressing**
17. **Lemon sherbet on pear half with custard sauce**
18. Lemon sherbet on pear half with custard sauce
19. Lemon sherbet
20. Unsweetened canned loganberries
21. Orange juice

22. **Cream of spinach soup**
23. **Crisp crackers**
24. **Grilled Canadian bacon—baked bananas in lemon syrup**
25. Casserole of minced beef with baked potato topping
26. Broiled cubed steak
27. Riced potatoes (omit on Soft Diet)
28. **Whole green beans**
29. **Raw vegetable salad bowl**
30. **Chef's dressing**
31. **Fruit compote—Christmas cookies**
32. Applesauce—Christmas cookies
33. Cherry gelatin cubes with custard sauce
34. Unsweetened canned fruit cocktail
35. Blended citrus juice
36. **Cornbread**

December 25

1. **Frosted grapes**
2. Blended juice
3. **Brown granular wheat cereal or corn flakes**
4. **Poached egg**
5. Crisp bacon
6. **Fruited buns**
7. **Tomato bouillon**
8. **Crisp wheat wafers**
9. **Roast turkey with dressing—gravy and cranberry stars**
10. Roast turkey
11. **Whipped potatoes**
12. Whipped potatoes
13. **Brussels sprouts**
14. Sliced beets
15. **Grapefruit, avocado and maraschino cherry salad**
16. **French dressing**
17. **Mincemeat tart**
18. Strawberry ice cream meringue
19. Lime sherbet
20. Fresh strawberries
21. Grapefruit juice

22. **Oyster stew**
23. **Oyster crackers**
24. **Salad plate—pineapple, peach, banana, orange and stuffed prune salad—cream cheese sandwiches**
25. Baked cheese sandwich
26. Cold sliced turkey and cold roast beef
27. Baked sweet potato (omit on Soft Diet)
28. **Asparagus tips**
29. **Celery curls**
30. ———
31. **Angel food cake and fruit cake**
32. Canned pears—angel food cake
33. Baked custard
34. Unsweetened canned pears
35. Pear and cherry nectar
36. ———

1. **Orange juice**
2. Orange juice
3. **Wheat and barley kernels or farina**
4. **Soft cooked egg**
5. Bacon
6. **Toast**

7. **Vegetable soup**
8. **Chinese crackers**
9. **Baked breaded cod fillets—tartar sauce**
10. Baked cod fillets
11. **Parsley potatoes**
12. Parsley potatoes
13. **Scalloped tomatoes and celery**
14. French green beans
15. **Hearts of lettuce salad**
16. **Russian dressing**
17. **Whole peeled apricots—coconut cookies**
18. Whole peeled apricots
19. Orange ice
20. Fresh pineapple
21. Blended citrus juice

22. **Cream of mushroom soup**
23. **Melba toast**
24. **Cheese souffle—grape jelly**
25. Cheese souffle—jelly
26. Low fat tuna
27. Baked potato
28. **Spinach**
29. **Grapefruit and diced celery salad**
30. **Parisian dressing**
31. **Banana cake with seafoam icing**
32. Prune whip
33. Floating island
34. Unsweetened canned bing cherries
35. Mixed fruit juice
36. **Parker House rolls**

December 27

1. **Fresh pear**
2. Blended citrus juice
3. **Oatmeal or cream of rice cereal**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Cream of spinach soup**
8. **Croutons**
9. **Roast fresh ham**
10. Roast veal
11. **Sweet potato casserole with marshmallows**
12. Whipped potatoes
13. **Swiss chard with lemon**
14. Green peas
15. **Stuffed celery and ripe olives**
16. ———
17. **Latticed cranberry pie**
18. Baked caramel custard
19. Cherry sponge
20. Grapefruit sections
21. Orange juice

22. **Tomato juice**
23. ———
24. **Braised short ribs of beef**
25. Beef and noodle casserole
26. Broiled cubed steak
27. Noodles (omit on Soft Diet)
28. **Carrot quarters**
29. **Cabbage and green pepper slaw**
30. **Sour cream dressing**
31. **Baked caramel custard**
32. Canned pears
33. Baked custard
34. Unsweetened canned apricots
35. Beef bouillon
36. **Hard rolls**

December 28

1. **Half grapefruit**
2. Grapefruit juice
3. **Crisp oat cereal or hominy grits**
4. **Soft cooked egg**
5. Link sausage
6. **Sweet rolls**

7. **Apricot nectar**
8. ———
9. **Roast leg of lamb—mint jelly in lettuce cup**
10. Roast leg of lamb
11. **Paprika potatoes**
12. Paprika potatoes
13. **Broccoli au gratin style**
14. Mashed yellow squash
15. **Cinnamon apple salad on endive**
16. **Whipped cream dressing**
17. **Chocolate chip ice cream**
18. Chocolate chip ice cream
19. Lemon ice
20. Unsweetened canned loganberries
21. Consomme

22. **Washington chowder**
23. **Crisp crackers**
24. **Creamed dried beef on Chinese noodles**
25. Toasted minced chicken sandwich—peach half on lettuce
26. Cold sliced veal
27. Baked potato
28. **Asparagus tips**
29. **Fresh pear, orange and sardines grape salad**
30. **Cream mayonnaise**
31. **Prune cake with caramel icing**
32. Lime gelatin cubes
33. Lime gelatin cubes with custard sauce
34. Unsweetened canned prune plums
35. Cranberry and apple juice
36. **Toasted French bread**

December 29

1. **Orange juice**
2. Orange juice
3. **Brown granular wheat cereal or puffed rice**
4. **Poached egg**
5. Canadian bacon
6. **Apple Kuchen muffins**

7. **Consomme**
8. **Whole wheat wafers**
9. **Pan-fried cubed steak**
10. Broiled chopped steak
11. **Quartered potatoes in cream sauce**
12. Riced potatoes
13. **Green beans with onion**
14. Green beans
15. **Tossed raw vegetable salad bowl**
16. **Celery seed French dressing**
17. **Strawberry shortcake**
18. **Strawberry Bavarian**
19. **Strawberry gelatin**
20. Unsweetened canned fruit cocktail

21. Grapefruit juice
22. ———
23. **Cream of chicken soup**
24. **Saltines**
25. **French toast with syrup—crisp bacon strips**
26. Pureed corn pudding—crisp bacon—spinach
27. Broiled lamb chop—spinach
28. Parsley potatoes (omit on Soft Diet)
29. ———
30. **Tomato and asparagus salad**
31. **French dressing**
32. **Grapefruit, red apple, grape and banana cup**
33. Bananas and orange sections
34. Chocolate blanc mange
35. Fresh pear
36. Pineapple juice

December 30

1. **Tangerines**
2. Blended citrus juice
3. **Corn flakes or rolled wheat**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Beef bouillon**
8. **Melba toast**
9. **Roast veal with dry dressing**
10. Roast veal
11. **Oven-browned potatoes**
12. Potato balls
13. **Mashed rutabagas**
14. Asparagus tips
15. **Pineapple ring salad with cranberry relish**
16. ———
17. **Coconut cream pie**
18. Cream pudding with orange sections
19. Orange rennet-custard
20. Orange slices
21. Orange juice

22. **Cream of tomato soup**
23. **Croutons**
24. **Chicken chow mein on rice**
25. Baked chicken and rice
26. Hot sliced chicken
27. Steamed rice (omit on Soft Diet)
28. **Baked acorn squash**
29. **Hearts of lettuce salad**
30. **Paprika French dressing**
31. **Glazed baked apple**
32. Baked apple without skin
33. Cream pudding
34. Unsweetened canned loganberries
35. Grapefruit juice
36. **Hot rolls**

December 31

1. **Half grapefruit**
2. Grapefruit juice
3. **Farina or wheat and barley kernels**
4. **Soft cooked egg**
5. Bacon
6. **Toast**

7. **Cream of asparagus soup**
8. **Toast sticks**
9. **Baked smoked ham**
10. Roast pork
11. **Mashed potatoes**
12. Whipped potatoes
13. **Cabbage wedge with peas**
14. Green peas
15. **Waldorf salad**
16. ———
17. **Date and nut torte, whipped cream**
18. Prune whip
19. Maple sponge
20. Fresh pineapple
21. Blended citrus juice

22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Scrambled eggs with egg garnish—stuffed potatoes**
25. Grilled chicken livers—broiled tomato
26. Cold lean pork—broiled tomato
27. Broiled baked potatoes
28. ———
29. **Carrot sticks—olives**
30. ———
31. **Frozen icing cherries**
32. Frozen icing cherries
33. Ice cream balls
34. Fresh pineapple cup
35. Blended juice
36. **Bordeaux rolls**

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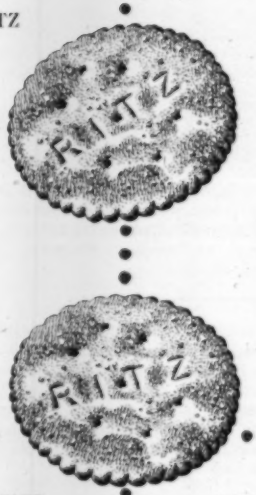

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PERSONAL News

F. ROSS PORTER, superintendent of Duke Hospital, Durham, N. C., has been granted a leave of absence to undertake a 14-month assignment as hospital administration adviser to the Mutual Security Agency Mission to Formosa.

MR. PORTER

Mr. Porter, a former trustee of the American Hospital Association, will work with Formosan and Nationalist Chinese hospital administrators to improve standards and quality of medical care. He will organize and direct a program to coordinate medical care services between hospitals and health centers, acting as consultant in teaching Formosan officials what equipment to buy, how to distribute professional personnel and how to use subsidiary workers.

During Mr. Porter's absence, J. MINETREE PYNE and LOUIS SWANSON will serve as co-superintendents of Duke Hospital. AL HERRON, recent graduate of the Duke Hospital course in hospital administration, has been appointed administrative assistant in charge of the business office.

SISTER M. FELICITAS has been appointed administrator of Braddock (Pa.) General Hospital. She succeeds SISTER MARY ANICETA, administrator of the hospital since 1935, who has assumed her duties at the San Rosaria Health Resort, Cambridge Springs, Pa.

Sister Felicitas is a graduate of St. John's Hospital School of Nursing, Pittsburgh, and a former instructor at the school. She received her bachelor's degree in nursing at St. Louis University and a master's degree in hospital administration at Catholic University of America, Washington, D. C.

DR. JAMES P. DIXON JR. has been appointed acting assistant director of the Public Health Service's new 500-bed Clinical Center for Research, Bethesda, Md. He formerly was commissioner of health for Philadelphia. He also held a similar position in Denver.

In 1946, Dr. Dixon was appointed medical director of the Denver General Hospital. He received his master's degree in hospital administration from Columbia University in 1947 after serving his administrative residency at Episcopal Hospital in Philadelphia.

Dr. Dixon is a member of the American Hospital Association and the American College of Hospital Administrators.

ESTHER I. BUZZALINI has been appointed administrator of the Bound Brook (N.J.) Hospital. She formerly was director of social service and the outpatient department of the Staten Island (N. Y.) Hospital.

LLOYD G. JENSON, administrator of Saunders County Hospital, Wahoo, Neb., has assumed his duties as superintendent of Children's Memorial Hospital, Omaha.

Mr. Jenson succeeds PHYLLIS LEVENS, who resigned after a year as superintendent of the hospital.

Mr. Jenson received his master's degree in hospital administration from Washington University and served his administrative residency at Ancker Hospital, St. Paul, Minn.

JOSEPH L. WILLIAMS has resigned as superintendent of the Mid-Valley Hospital, Peckville, Pa. He had been at the hospital since 1947.

Before accepting the Peckville position, Mr. Williams had been associated with hospitals in Michigan and Wisconsin.

LEROY G. PARRISH is now administrator of the Manitowoc County Memorial Hospital under construction in Manitowoc, Wis. He will assist in the building program for the hospital, scheduled to be completed next May.

Mr. Parrish formerly was acting administrator of the Sunbury (Pa.) Community Hospital. Before assuming that job last May, he had served in the x-ray department of the hospital since 1945. He has been with the Wilkes-Barre (Pa.) General Hospital, the Harrisburg (Pa.) Hospital and several hospitals in Ohio. Before entering the hospital field in 1942, he had worked for a national manufacturer of x-ray equipment.

SISTER M. THEODORE, formerly superior of the Mercy Convent in Scranton, Pa., has been appointed assistant superintendent of Mercy Hospital in Scranton. SISTER M. AVELLINO, superintendent of the hospital, is now also superior of the convent.

At St. Mary's Hospital in Scranton, SISTER M. IRMA has been appointed superintendent succeeding SISTER MARY CLEMENT.

ARTHUR G. TURNER has resigned as director of the Woodland (Calif.) Clinic Hospital to accept a position with the Kaiser-Fontana Hospital Association, Fontana, Calif.

MR. TURNER

The Kaiser-Fontana Hospital Association includes the Kaiser-Fontana Hospital and clinics in Fontana and Ontario, Calif.

Mr. Turner's appointment is effective November 1.

JOHN E. PETERSON, formerly administrative assistant of the Highland-Alameda County Hospital, Oakland, Calif., has been appointed consultant to the Health Division of the Health and Welfare Council in Philadelphia.

Mr. Peterson, a member of the American Hospital Association, succeeds CLYDE E. ARBEGAST, who now is executive secretary of the Maryland Heart Association.

NORMAN W. SKILLMAN has been appointed director of the Chester County Hospital, West Chester, Pa. He succeeds EUGENE V. A. ADAMS.

MOTHER MARY EDITH, administrator of the Ohio Valley General

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Large illustration: Dormitory Room No. 158 with its compactly designed Dust Desk F-142-21. Each student has own drawer and book shelves. Other pieces are: Chest F-142-24, with Mirror FM-42; Chairs F-711, Arm Chair F-762; Night Table F-142-14. Below: Single Desk F-142-11.

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Illustrated above: Single Desk F-142-11.

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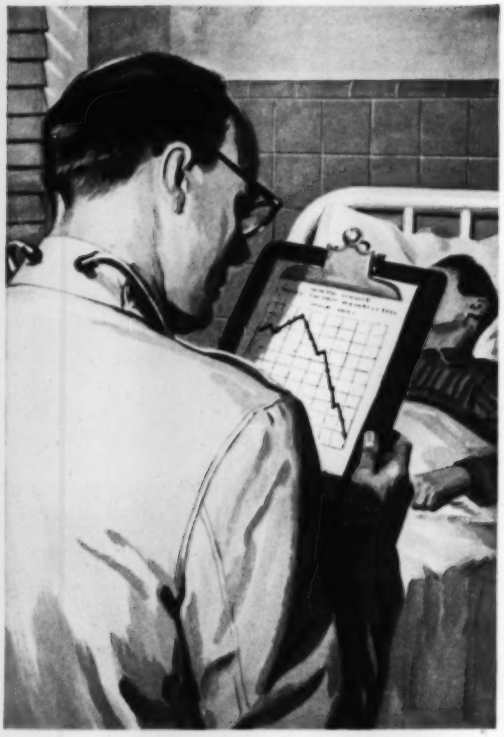

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Hospital, McKees Rocks, Pa., has resigned from the position to attend the graduate school of hospital administration at St. Louis University. She had been head of the hospital since 1946.

Mother Edith's successor is MOTHER MARGARET MARY, formerly of Mercy Hospital, Altoona, Pa.

EARL W. HAGBERG has assumed duties as administrator of Winona (Minn.) General Hospital.

Mr. Hagberg is a graduate of the University of Illinois and of Northwestern University's program in hospital administration. He served his administrative residency at Illinois Masonic Hospital, Chicago.

MIRIAM LOVELL NEFF, administrative assistant of St. Barnabas Hospital for Chronic Diseases, New York City, for the past five years, has resigned to become administrative associate of the University Hospitals, Iowa City, Iowa.

MRS. NEFF

Mrs. Neff was graduated from Columbia University with a master's degree in hospital administration. She is a member of the American College of Hospital Administrators and a personal member of the American Hospital Association.

EDGAR O. MANSFIELD has been appointed administrative assistant of Mound Park Hospital, St. Petersburg, Fla.

Mr. Mansfield was graduated with a master's degree in hospital administration from Northwestern University and served his residency at the Mound Park Hospital. His principal duty at the hospital will be assisting in the establishment of procedures and systems for use in the new hospital building which is expected to open this month.

G. H. SHAW, formerly assistant administrator of the Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec, for nine years, has been appointed personnel officer of the Royal Victoria Hospital, Montreal.

Mr. Shaw is a graduate in economics of McMaster University in Canada. Before going into the hospital field, he served with Canadian companies and industries.

FRANCETTA E. PETERS has resigned as administrator of the William Crispe Hospital, Plainwell, Mich.

Miss Peters has served as hospital consultant for the Illinois State Department of Health, as administrator of South Haven (Mich.) Hospital, and as director of nurses at the South Haven Hospital.

MRS. ELSIE SPEARS has been appointed superintendent of Port Allegany (Pa.) Community Hospital. She succeeds ESTELLE KELSO, who resigned recently because of ill health.

JOSEPH F. MCALOON has been appointed administrator of Memorial Hospital, Hollywood, Fla. He formerly was supervisor of the Hospital Division, Florida State Improvement Commission, Tallahassee. The Memorial Hospital in Hollywood is now under construction and is scheduled to open early in 1953.

Mr. McAloon is a graduate of the program in hospital administration at Northwestern University.

DR. THEODORE W. STEEGE, assistant medical director of the Hartford (Conn.) Hospital, has resigned to return to private practice.

The Veterans Administration has announced the following appointments:

DR. IRVIN J. COHEN is now manager of the new Veterans Administration Hospital in Baltimore, Md. He formerly was chief of professional services at the veterans hospital in the Bronx, N. Y.

DR. CHARLES S. LIVINGSTON, manager of the Veterans Administration Hospital at Outwood, Ky., has been transferred to the veterans hospital at Butler, Pa., where he is the new manager. He succeeds DR. JOSEPH L. CAMPBELL, who is on leave of absence.

DR. ERNEST M. TAPP has been appointed manager and chief of professional service at the Veterans Administration Hospital in Poplar Bluff, Mo. Dr. Tapp, formerly chief of professional service at the veterans hospital in Grand Junction, Colo., succeeds DR. WILLIAM J. MCCARTY, who has been appointed manager of the Veterans Administration Hospital in Vancouver, Wash.

H. M. CROW JR. has been appointed superintendent of the Fulton County Medical Center, McConnellsburg, Pa. He succeeds MRS. THELMA BERGSTRESSER, R. N., who now is superintendent of the Brodstone Memorial Hospital, Superior, Neb. She replaces MRS. MARIE HARTEL.

MANUEL COHEN has been appointed assistant director of Montefiore Hospital, New York City. He formerly was an administrative resident at the hospital.

MR. COHEN

Mr. Cohen received his master's degree in hospital administration from Yale University. During World War II, he served with the Army in a medical administrative capacity. He is a member of the American Hospital Association and the American Public Health Association.

SISTER MARIA DOLORATA, administrator of St. Joseph's Hospital, Reading, Pa., has been appointed administrator of St. Joseph's Hospital in Philadelphia. She succeeds SISTER M. ST. ROBERT, who will take over the administration of the Reading hospital.

DR. JAMES A. SHANNON has been appointed associate director of the National Institutes of Health. He succeeds DR. NORMAN H. TOPPING, who now is vice president in charge of medical affairs at the University of Pennsylvania.

For the past three and one-half years, Dr. Shannon has served as associate director of the National Health Institute, a major research unit within the National Institutes of Health.

Dr. Shannon previously was director of the Squibb Institute for Medical Research, New Brunswick, N. J. Before that he was professor of pharmacology of the New York University Medical College and director of research service, Third

New York University Medical Division, Goldwater Memorial Hospital, New York City.

CHARLES R. E. BADGER, a graduate of the school of hotel management at Cornell University, has been appointed deputy administrative manager of the J. C. Blair Memorial Hospital, Huntingdon, Pa.

IRENE F. SHARPE is now administrator of Garrett County Memorial Hospital in Oakland, Md. She formerly was at Wayne County Memorial Hospital, Honesdale, Pa.

E. VERA DEAN, R. N., has been appointed administrator of the New England Hospital, Boston. She succeeds EDMUND R. MATTOS.

Miss Dean had been active in public health work for 15 years before entering the hospital field. From 1944 until 1951, she served as administrator of the W. B. Plunkett Memorial Hospital, Adams, Mass.

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ETHEL FRANKLIN has been appointed administrator of Bethesda Hospital, Hornell, N. Y.

Miss Franklin succeeds HELEN DUMACK, who has resigned to accept the administratorship of a state hospital in New York.

ANDREI MEZEI and DR. MAX FUCHS have joined the staff of Mount Sinai Hospital of New York

MR. MEZEI

DR. FUCHS

City as administrative assistants.

Mr. Mezei will be in charge of administrative services for the private and maternity pavilions. Dr. Fuchs will be in charge of outpatient services and special projects.

Mr. Mezei has been at Mount Sinai for 26 years in a number of management positions and served recently as laundry supervisor.

Dr. Fuchs came to Mount Sinai last year as a Goldwater Fellow in hospital administration.

HERMAN R. GOLDBERG has been appointed administrative assistant to the executive director of the Albert Einstein Medical Center, Philadelphia. He formerly was administrator of the Eastern Division of the medical center.

DR. EDWARD N. PLEASANTS has joined the staff of the Essex County Overbrook Hospital, Cedar Grove, N. J., as assistant superintendent and assistant medical director.

Dr. Pleasants formerly was superintendent of the North Carolina State Hospital, Raleigh, for three years. Before that he was clinical director of the New Jersey State Hospital at Marlboro.

DREW J. THOMAS has been appointed director of the Nathan Littauer Hospital in Gloversville, N. Y. He formerly was administrator of the West Hudson Hospital in Kearny, N. J., for three years.

Mr. Thomas succeeds DR. FERDINAND HAASE JR.

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A method of treating hospital linen with an oil emulsion

JOSEPH L. CAMPBELL, M.D.

MEDICAL RESEARCH has proved that bacteria, particularly those organisms which are responsible for respiratory disorders and tuberculosis, are airborne.[1,2] Investigations have shown that a large reservoir of bacilli exist in bed linen; in the dust on the floors, and in the lint thrown into the air with the movements of patients.[3] Research indicates that the oil treatment as applied to the bed linen, combined with oil treatment of flooring, has reduced bacterial dispersion by 90 per cent and that the incidence of respiratory infection has been greatly lowered with oil-dust control methods.[4,5,6]

The bacteria and viruses of human origin exist in the air in droplets, droplet nuclei and dust.[7] Dust offers an excellent medium for the survival and multiplication of these micro-organisms, and the content of the atmosphere is constantly being replenished by bacteria and viruses stirred up by air currents.[8] The following is a logical sequence of events which occur in a large proportion of inter-ward and intra-ward infection:

1. Ejection of infected particles from the patient.

2. Direct transmission to other patients via the airborne route or through droplet nuclei contact is probably very limited. Most of these infected particles settle out quickly onto surfaces of the room.

3. Survival of these infected particles so that heavy concentrations are built up on these surfaces.

4. Repeated reintroduction of these particles into the air through dusting, mopping, bed-making, and other ward activities and by natural air currents.

5. Gradual extension of the infected area throughout the ward and to other wards.

Although professional personnel generally agreed that oil emulsion treatment of bed linen would greatly reduce the bacterial count in the air and eliminate a high percentage of dust and lint, no practical, economical and standard method of oil treatment of linen had been developed.[9] In 1948, the Veterans Administration introduced the procedures for the oiling of bed linen in hospitals and centers having tuberculosis patients. The oil emulsion adopted was T-13 oil emulsion, consisting of 13 per cent Triton NE (emulsifying agent) and 87 per cent medicinal mineral oil, thoroughly mixed to form a cream emulsion. The criteria established was the introduction of oil into the fabrics to the amount of approximately 2 per cent oil based on dry weight of the linen to be laundered.

This hospital immediately instituted the oil treatment of linen as recommended, but found that it was impossible to impregnate the linen with T-13 oil emulsion and that the T-13 oil emulsion was being completely wasted. This conclusion was based upon two facts:

1. Weighing of linen before and after treatment with T-13 oil emulsion showed no oil pickup by weight.

2. Oil was appearing at the hospital sewage disposal plant in such quantities as to disrupt the normal bacterial action.

A program was then initiated, utilizing a large number of products which might aid in the absorption of oil by the linen, but no substance could be found which, when combined with T-13 oil emulsion, would produce the desired results.

During this period, the hospital was attempting to eliminate the stains and unpleasant odors, which are common to hospitals providing medical care for geriatric patients. An extensive review was made of all bacteriostatic agents which were non-toxic, non-irritating and which would inhibit the growth of bacteria in the soiled linen. During this study, it was found that one particular product fulfilled all the requirements as to the medical section of the hospital and of laundry operations.

It was observed that during the period of laundering of the hospital linen treated with this bacteriostatic agent and T-13 oil emulsion, oil did not appear at the hospital sewage disposal plant. This observation was quickly followed up by the weighing of the linen, and it was found that linen so treated would absorb the T-13 oil emulsion in various percentages depending upon the amounts of T-13 oil emulsion and the bacteriostatic agent used in the standard 300 pound capacity washwheel.

The hospital experimented during the following year in varying the amount of T-13 oil emulsion, bacteriostatic agent, soap solution, and alkali in order to standardize a method of laundry operation which would produce consistent results over a long period of time, using as a criteria the following:

1. Consistent appearance of the T-13 oil emulsion in the linen in the amount of 2 per cent on the dry weight of the linen.

2. Absence of oil at the hospital's sewage disposal plant.

3. Disappearance of obnoxious odors and stains from the linen.

4. Consistent whiteness of the hospital linen.

5. Absence of any evidence of toxicity.

It was readily apparent that with the development of the process of oil treatment of hospital linen, which entailed a modification in the

Dr. Campbell is manager of the Veterans Administration Hospital, Butler, Pa. This article was reviewed by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

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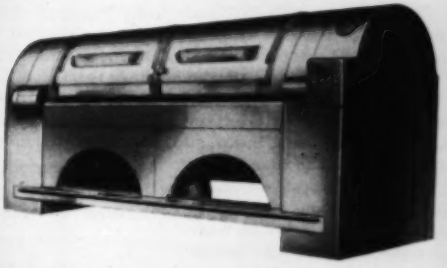

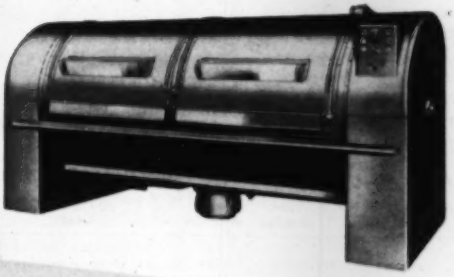

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Table 1

Washing formula—with T-13 oil emulsion, with the use of bacteriostatic agents. 300 lb. load of hospital linen in 42" x 84" washwheel.

Operations	Water level	Time minutes	Temp. degrees	Supplies used	Approx. cost
1. Suds	6"	8	160	10 qts soap solution	0.0825
2. Suds	6"	5	165	2 qts soap solution	0.0165
3. Rinse	10"	3	165	None	
4. Rinse	10"	3	165	None	
5. Rinse	12"	3	150	None	
6. Rinse	12"	3	130	None	
7. Oil treatment	4"	5	120	6 lbs T-13 oil	0.7032
				200 cc bacteriostatic agent	0.5000
			Total cost		**1.3022**

Total operation time: 37 minutes. Completed operation with PH range of 6.4 to 6.6. Soap solution consisted of 15 lbs. soap, 10 lbs. sodium metasilicate pentahydrate to 50 gals. of water. Oil penetration of the linen could be demonstrated at 2% dry weight of the linen. No oil could be demonstrated at the hospital sewage disposal plant.

standard accepted laundry formula and method of laundry operations, the apparent findings of this hospital should be checked by an individual familiar with all phases of laundry operations.

The director of the Ellen H. Richards Institute, Pennsylvania State College, was contacted and she consented to make a study of the soil removal properties and wear factor, using a Taber abraser with test pieces treated with T-13 oil emulsion and the bacteriostatic agent. The studies were based on the theoretical assumption that a sheet of moderate cost and intermediate construction presumably will withstand two years of wear, with laundering every two weeks, or 50 washings. The results of these studies were:

1. Percentage of soil removal efficiency—96.4 per cent.

2. Abrased specimens laundered with T-13 oil emulsion and the bacteriostatic agent showed a breaking strength loss of 65.2 per cent, while those specimens without oil showed a breaking strength loss of 85.2 per cent.

The accompanying tables illustrate the requirements for the normal operation of a washer which is a standard 42" x 84" washwheel, with a normal load of 300 pounds of linen, including total time of operation, steps involved and approximate cost of complete operation.

A comparison of tables 1 and 2 shows that the cost of materials is approximately equal when consideration is given to the elimination of wax for flatwork ironer with formula used in table 1 at the approximate cost of eighty cents per pound. Consideration has not been given to the savings in utilities, maintenance of equipment and manhours which result with the reduction in time necessary in the operation of the washer from 69 minutes to 37 minutes.

It is believed that the formula as shown in table 2 would probably have to be modified to meet the different water conditions existing in various parts of the country to obtain uniform results.

The experience gained at this hospital has shown that the utilization of sodium metasilicate pentahydrate in the amounts now utilized in most laundries will greatly affect the end results obtained with the use of T-13 oil emulsion, and is responsible for the formation of "gum-like" deposits and flakes on the washwheel and on the finished linen.

The oil treatment of hospital linens must be considered from a safety viewpoint. It must not present a fire hazard, and it must be safe to use in the operating rooms, recovery rooms and in patients' rooms who are receiving oxygen therapy. The National Bureau of Standards has approved the following safety methods.[9]

1. Cotton and woolen fabrics should not be oil treated to exceed 5 per cent by weight of the dry material.

2. The maximum temperature which may be used in a hot air drying tumbler is 230°F. After running at this temperature for 30 minutes, the material should be cooled by opening the cool air vents 10 minutes before the load is removed.

3. Bedding is never to be packed while hot, but should be shaken out and folded immediately upon removal from the dryer or ironer.

Experiments have shown that linens treated with oil up to 2 per cent of dry weight are safe to use in operating rooms, recovery rooms and in rooms where oxygen is being used, as linen so treated is conductive.[10]

It has been observed by the hospital employees that since the institution of this method of oil treatment of linen there has been a marked absence of lint in the laundry. This also has been noted by the group safety engineer, who has made the following comment: "As one visits the various laun-

Table 2

Washing formula—with T-13 oil emulsion, without the use of the bacteriostatic agents. 300 lb. load of hospital linen in 42" x 84" washwheel.

Operations	Water level	Time minutes	Temp. degrees	Supplies used	Approx. cost
1. Suds	6"	8	130	14 qts soap solution	0.1155
2. Suds	6"	10	165	8 qts soap solution	0.0660
3. Bleach	6"	8	150	5 qts 1% bleach	0.034
4. Rinse	6"	3	165	1 pt. sodium metas. phosphate	0.04
5. Rinse	12"	3	165	None	
6. Rinse	12"	3	165	None	
7. Rinse	10"	3	140	None	
8. Rinse	10"	3	120	None	
9. Sour	6"	8	120	2 oz. sour & blue combination	0.143
10. Oil treatment	10"	10	120	7½ lbs T-13 oil	0.8790
			Total cost		**1.2775**

Total operation time: 69 minutes. Completed operation with PH range of 6.6 to 6.9. Soap solution consisted of 25 lbs. soap, 25 lbs. sodium metasilicate pentahydrate to 50 gals. of water. No oil penetration of the linen could be demonstrated by weight. Oil could be demonstrated grossly at the hospital sewage disposal plant.

dries, there is always the ever-recurring problem of lint as a fire hazard, and on my first visit to the Veterans Administration Hospital at Butler, Pennsylvania, I was amazed that this problem did not exist." From a safety and fire prevention standpoint, the oil treatment of linen has definite merit.

Patients have commented favorably upon the soft texture of the hospital linen and the absence of the stiffness and irritation which are so often present in hospital linen. Physicians and nursing personnel have been impressed by the absence of skin irritation, which is often a complicating factor in chronically ill bed patients. Since the hospital has been treating its linen with T-13 oil emulsion and the bacteriostatic agent, decubitus ulcers have completely disappeared. This is a major triumph, for the average daily hospital census is 450 patients. The patients are all tuberculous, and a large percentage of the patients are seriously ill and confined strictly to their beds for long periods of time.

The results of a study of this nature, conducted by one hospital, cannot be considered as conclusive. The findings presented, however, appear to open up a new field in hospital administration as well as in laundry operation.

The comfort and welfare of the hospitalized patient, protection of the health of the hospital employee, the elimination of lint as a safety and fire hazard, the reduction in time required in laundry operation, and the prolongation of the life of the linen, far exceed in importance the cost of the oil treatment. The bacteriostatic germicidal and cationic agent greatly increases the cost of oil treatment, and the ideal technique is to utilize a one package product which combines the two necessary ingredients—the T-13 oil and the germicidal, cationic agent.

At the present time, this hospital is experimenting with such a product which is producing better results at a greatly reduced cost. This product also reduces to a minimum any margin of error which results with the use of two separate products.

REFERENCES

1. Robertson, O. H.: The Dispersal of Respiratory Pathogens in Relation to the Occurrence and Control of Airborne Infections. American Review of Tuberculosis, Feb. 1947. 55, 109-121.

2. Editorial. The Control of Air-Borne Infections. American Journal of Public Health, Apr. 1947. 37, 450-453.

3. Loosli, C. G., and Robertson, O. H.: Recent Studies on the Control of Dust-borne Bacteria by The Treatment of Floors and Bedclothes with Oil. American Journal of the Medical Sciences, Feb. 1945. 209, 166.

4. Loosli, C. G., Wise, H., Lemon, H. M., Puck, T. T., and Robertson, O. H.: The Oil Treatment of Bedclothes for the Control of Dustborne Infections, II. The Use of Triton Oil Emulsion (T-13) as Routine Laundry Procedure. American Journal of Hygiene, March 1946. 43, 105.

5. Wells, W. F., and Wells, M. W.: Air-borne Infection. Journal American Medical Association, Nov. 21, 1936.

6. Wright, Joyce, Kruikshank, Robert, and Gunn, William: The Control of Dust-borne Streptococcal Infections in Measles Ward. British Medical Journal, May 6, 1944. 1, 611-614.

7. Harris, M. C., and Shure, N.: Evaluation of a New Method of Dust Control. California Medicine, Jan. 1952. 76, 30-33.

8. Sullivan, Frank J.: Hospital Topics, June 1952. 30, 26, and July 1952. 30, 26-27.

9. Veterans Administration, Construction, Supply and Real Estate, Information Bulletin, IB 11-104, Mar. 1948.

10. Thomas J. George: personal communication with the author.

LAUNDRY MANAGEMENT COMMENT

Automatic washer

A new automatic washer was introduced for the first time at the A. I. L. convention in Atlantic City last month. This washer, it is claimed, provides better control over washing quality which results in a reduction of tensile strength losses and less dependence upon skilled help. (11L-1).*

The washer is said to provide unlimited formula flexibility. There are no formula rolls to cut and no plates to change because all settings are simply made on the control panel. After the operator has selected the desired formula, he merely pushes the "run" button on the panel. The remainder of the washing operations are performed by the washer automatically, including the addition of enough soap for the soil content of each bath.

Another feature of the machine is the fact that an entire day's work can be completed without refilling supply tanks. These tanks, which come with the machine, can be installed adjacent to the washer or in remote locations.

The washer represents 10 years of constant field research, engineering development and laboratory testing.

Laundry disinfectant

Preliminary experiments by the Bureau of Human Nutrition and Home Economics of the U. S. Department of Agriculture with disinfectants of the quaternary ammonium compound type show that solutions recommended by manufacturers in general are too weak to be effective.

Continuing the research, they have determined proportions required in rinse water to be effective for three kinds of use: (1) Preventing ammonia formation in fabric, said to cause "ammonia dermatitis" and delaying development of odors in soiled diapers held before washing; (2) sanitizing the fabric by reducing bacterial count to one-tenth of one per cent, and (3) completely disinfecting the fabric.

All five compounds were found capable of deodorizing and delaying ammonia formation for 16 hours, one, four, and seven days, but the compounds differed widely as to strength of solution needed. The usual commercial recommendation for this use is one part compound to 16,000 parts water, or one ounce to 30 pounds of dry cloth. This dilution proved effective for 16 hours and when rinsing lasted 10 minutes at a temperature of 113 degrees F. To prevent odor formation in garments likely to await laundering longer than 16 hours, the bureau points out that far stronger solutions are needed.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

Four authors produce two new volumes on group leadership

IT IS APPROPRIATE that these two books*, both recently published, be mentioned together. They can even be considered as companion books, although they still will be of value if read separately. Both carry an identical sketch on the cover by cartoonist Roy McKie; both are jointly written (Trecker and Trecker is a husband-wife combination and Brown and Geis is a mother-daughter authorship); both are published by the Woman's Press, and both have valuable guidance for the hospital administrator, board president, departmental head, volunteer director, and hospital auxiliary leaders.

Although the experience of the writers does not include the hospital and hospital auxiliary, the situations can well be applied to the health field. Thus, they assist professional and lay leadership in their daily experiences of dealing with and serving both the individual as a public and all the "publics" interested in the sick and who come in contact with the hospital.

Mr. and Mrs. Trecker outline the fundamentals of democratic group leadership and then translate these fundamentals into the day-to-day handling of group matters. For the past 20 years, they have been active in a great variety of groups and organizations, many of which they have served in a leadership capacity. Harleigh Trecker is dean of the School of Social Work, Connecticut University, and recently was on the faculty of the Graduate School of Social Work of the University of Southern California. He is a graduate of the School of Social Work Administration, University of Chicago, and has worked with community planning agencies in Chicago and Los Angeles. He also is author of *Group Process in Administration* and *Social Group Work—Principles and Practices*.

Audrey Trecker helped organize the PTA in her sons' school in Los Angeles, served as its president, and was honored with a life membership. She has been an active campus wife and a member of church groups, YWCA, League of Women Voters. She is a believer that people in groups can work wonders in their communities.

As Mr. and Mrs. Trecker state, "No small part of what we have learned and wish to share is a blending of the 'theoretical' and the 'practical'." Expressed another way, "We know that what we have said herein does work and does meet the twin tests of scientific fact and practical problem solving."

The opening sentences in the book give the key to this presentation and why it is just as valuable for the person who has been on the job and is a so-called "seasoned" leader as it is for the one who is accepting responsibility for the first time:

> "You have had your picture in the newspaper. The installation ceremony is over. You have been given a pin, perhaps handed a polished walnut gavel. Congratulations have poured in. It sounds, looks and feels awfully good. Maybe you think it will be easy. Watch out now. This is as good a time as any to sit down, take a deep breath, pull yourself together, and take a hard realistic look at your job. Visualize the work that lies ahead. See it in terms of single meetings which will follow one upon the other. Think about your job. How will you go about it? Have you got what it takes?"

From there on, the Treckers take the reader along a clear cut, concise path for the group leader, finally closing with this statement: "The future belongs to those who make it their business to be productive community citizens."

The *Handbook for Group Leaders* is particularly important for women to read, and it goes into more precise details of methods and procedures of working with women's organizations. "This book," the authors state, "has come out of our combined experiences as PTA president, church circle leader, community board member, campus activity participant, student association president, camp advisor and as professional group consultants. These groups have asked us, over and over again, the questions which we have tried to answer in the following pages . . . we hope that our readers will find help in doing better those volunteer jobs which they want to do."

The chapters, "Pointers on Membership," and "Public Relations," are a fine supplement to *A Guide—Membership and Public Relations for Women's Hospital Auxiliaries* prepared by the Committee on Women's Hospital Auxiliaries of the American Hospital Association.

Ann Brown is the wife of Dr. Porter Brown, a noted physician and public health consultant in Salina, Kansas, and Sally Brown Geis is program coordinator of the Community College, University of Denver. Community College is an outstanding experiment in adult education. Together, the authors' years of active and practical experiences are reflected in this handbook.—ELIZABETH M. SANBORN.

*HOW TO WORK WITH GROUPS. Harleigh B. Trecker and Audrey R. Trecker. Woman's Press, New York. 1952. 162 pp. $3.

*HANDBOOK FOR GROUP LEADERS. Ann Curphey Brown and Sally Brown Geis. Woman's Press, New York. 1952. 212 pp. $3.

History of medicine

THE ADVANCE TO SOCIAL MEDICINE. Dr. Rene Sand. Staples Press, Inc., 70 E. 45th St., New York 17. 1952. 600 pp. $8.50.

It is an unfortunate fact that men immersed in the practical affairs of

life have too little leisure to delve into the backgrounds of their professions and activities. Yet, what happens today is rooted in the events of yesterday. To know the broad forces which have welded the contemporary hospital into the effective instrument of society which it is today is a stepping stone to better patient care tomorrow.

Forthcoming students and medical care executives will long owe a debt of gratitude to Dr. Rene Sand. His contributions to the field of hospitals and social medicine have enriched not only the literature, but also have done much to focus our attention on the relationships between medicine as a science and man as a member of society. But it is in this, his latest work, that Dr. Sand has made his greatest contribution.

The book's encyclopedic nature and the author's acquaintance with the historical details and personalities involved point to a degree of scholarship and erudition rarely encountered in this day of digests and hastily formed manuals. Every subject, even those only remotely connected with the field, is discussed. The account of the history of hospitals is particularly noteworthy. It is only when the author discusses topics not directly germane to his major field of interest that he runs into trouble. For example, part eight on the "History of the Studies of Man" is a somewhat superficial treatment of sociology, demography, education, statistics and other social sciences. Here one encounters several terms and classifications not commonly employed in this country. On the other hand, the author has annotated the text with copious references which will give any interested reader ample clues, should he desire to delve further into any of these subjects.

There are two characteristics of the book which are disturbing. The first, although it would be a difficult one to correct, is that many of the topics reappear in the various sections of the book. Thus, at first glance it might appear that a given subject is only summarily treated; however, in a later section, it may receive detailed analysis. And the index is not too helpful in correcting this.

Another weakness is that the author, at times, stresses the details to the detriment of the whole. In social medicine, a synthesis of all the parts into a meaningful entity is essential. So long as the various components of medical care are compartmentalized into neat little packages, the greater will be the delay in the acceptance of social medicine as a realistic approach to man's physical and mental ailments. As the book is primarily a history, these weaknesses do not markedly detract from its over-all value.

Many readers undoubtedly will quarrel with some of Dr. Sand's ideas and conclusions. This will be good, for if everyone unquestionably accepted every statement in this exhaustive treatment, the author would have cause to worry. There can be no doubt, however, that anyone interested in medical care or hospitals who will take the time to study this remarkable book, will emerge from the experience a wiser and a more understanding person.—JOSEPH PETERS, Division of Hospital and Medical Resources, Public Health Service, Washington, D. C.

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library — Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

New films

HOSPITAL FOOD SERVICE PERSONNEL TRAINING—(16 mm., black and white, sound. Parts 1-3, approx. 15 min. each; Part 4, approx. 40 min.). Produced by U. S. Army in 1949 and 1950. Free loan from nearest Army headquarters film library. Loan from the library of the American Hospital Association, $10 for three days for complete set of four films; individual titles not available singly.

This series consists of four parts: introduction, the individual, equipment, and serving food. All of the four are excellent training films for food handlers. With interesting narration and good photography, ideas of sanitation, personal cleanliness, safety habits, and others are presented. The films are recommended for inclusion in the orientation and training programs for every kitchen employee.

YOU CAN BE SAFE FROM X-RAYS—(16 mm., black and white, sound, 10 min.). Prepared by the Division of Chronic Disease and Tuberculosis, Public Health Service, 1952. Rental from the library of the American Hospital Association, $4 for three days.

This training aid for x-ray technicians and other personnel stresses the hazards of secondary radiation in x-ray installations and outlines protective measures against over-exposure to radiation. In cartoon style, it depicts an x-ray technician who takes excellent care of his equipment but does not use the same care in protecting himself.

CONCEPT OF MATERNAL AND NEONATAL CARE (ROOMING-IN) — (16 mm., black and white, sound, 26 min.). Produced by George Washington University School of Medicine, Washington, D. C., and Medical Film Institute of the Association of American Medical Colleges in 1951. Rental from the library of the American Hospital Association, $4 for three days, $1 for each additional day.

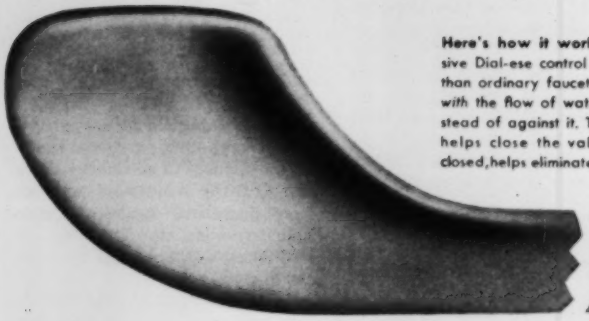
Designed for showing to professional audiences, doctors, nurses, and hospital administrators, this film shows the approach and care of the pregnant mother and newborn infant. In the hospital of the film, emphasis is placed upon a balance of scientific facilities, educational experiences and homelike accommodations of rooming-in. The discussion of rearrangement of conventionally designed hospitals is of interest to both administrators and architects. A fact sheet, an outline and a bibliography are also available for use in showing this film.

The film also should be good for training nurses and nursing aides in maternity care.

HANDLING AND CARE OF THE PATIENT (IN ANESTHESIA)—(16 mm., black and white, sound, 26 min.). Produced by the British Ministry of Information. Loan from International Film Bureau, Inc., 57 E. Jackson Blvd., Chicago 4, or the library of the American Hospital Association, $4 for three days.

One of a series on the "Technique of Anesthesia," this film shows by contrast the right and wrong ways of preparing the patient for surgery. The mental aspects as well as the physical preparation are emphasized. The film includes both pre- and post-operative care pointers. It should be excellent for training surgical nurses and operation room teams.

THE PREFERRED HOSPITAL PLUMBING



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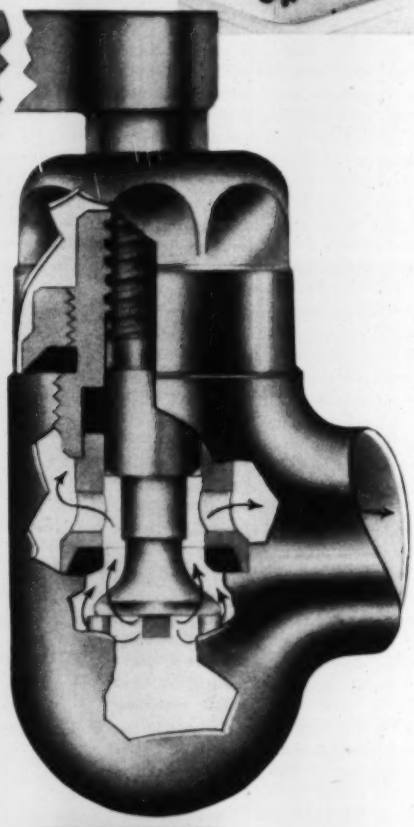

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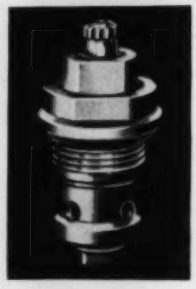

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Health Group Holds Final Hearing

The manifold problems of hospital financing received a full share of attention at the final fact-finding hearing of the President's Commission on Health Needs of the Nation, held October 7-8 in Washington. Technical experts in many fields of health service testified at the hearing, presenting a distillation of opinions and data designed to aid the commission in preparation of its report to President Truman. It will be submitted to the White House late in December.

Dr. Edwin L. Crosby, president, American Hospital Association, and director, Joint Commission on Accreditation of Hospitals, spoke to the commission—and answered numerous questions—on unmet needs in hospital services.

Shortcomings in the present system of financing were discussed by E. A. van Steenwyk, executive director, Hospital Service of Philadelphia (Blue Cross). Development of Blue Cross and Blue Shield plans was traced by William S. McNary, executive vice president and general manager of Michigan Hospital Service, and George W. Cooley, assistant secretary, Council on Medical Service of The American Medical Association. The 22 panel participants also included Harry Becker, associate director, Commission on Financing of Hospital Care.

Other speakers dealt with compulsory health insurance, unmet public health needs, professional training, indemnity insurance against hospital and medical expenses, industrial plans and public assistance.

Dr. Crosby emphasized that hospitals should receive full reimbursement for the cost of service they provide. He made it clear that "cost" includes depreciation of buildings and equipment and expenditures for education and research.

He praised achievements of the Hill-Burton expansion program and advocated its extension beyond scheduled expiration in 1955.

Assurance of a living wage and security to hospital workers, regionalized hospital services and provision of adequate funds to support research in administration and management were other points stressed by Dr. Crosby.

"The American people have already indicated their willingness to support good hospital care for the individual patient as evidenced by the fact that they have the best hospital care available," he told the commission. "I should like to say that if the people of the United States will support an expanding and growing program of medical care in hospitals, for both bed and ambulatory patients, the hospital profession will provide the most economic and efficient service of the highest quality for the patients they care for."

Mr. van Steenwyk drew mainly on his experience in Philadelphia to support his point that hospitals are reimbursed only fractionally for care given to indigents. If payments were adequate, Blue Cross rates could be lowered substantially, or much more coverage could be given to members at the existing rates.

"This problem hampers the aspirations and ambitions of Blue Cross nation-wide," said Mr. van Steenwyk. "All Blue Cross plans look forward to the time when their voluntary organization can move forward into the realms of preventive medicine and other services not now provided. Such aspects have not been overlooked; they have only been delayed."

Mr. McNary said Blue Cross regards itself as "the social program of the American community hospitals," with the responsibility of extending coverage wherever possible. Criticizing federal government policy which forbids payment of Blue Cross premiums by federal employees through payroll deductions, he asked whether there is "a wish on the part of some not to be too successful in solving, by voluntary means, an acute social problem that has often provided useful political ammunition."

The Cooley statement was even more blunt in its criticism of federal health policy. He said gains which voluntary insurance has made in recent years "should very definitely entitle it to an opportunity to work unhampered by disruptive activities of agencies of the federal government." These obstructions, he said, have taken the form of propaganda and threats of restrictive legislation.

The ultimate test of voluntary prepayment plans, said Mr. Becker, is the extent to which they accomplish these objectives:

1. Provision of comprehensive benefits, including a major share of cost of protracted and costly illnesses.
2. Development of techniques for successful recruitment into membership of the entire employed population and their dependents.
3. Creation of incentives for expanding health services to include preventive and diagnostic care.
4. Provision of prepayment on "an economical and efficient basis."
5. Assurance of consumer representation at the policy-making level.

Magnuson Statement: Dr. Paul B. Magnuson, chairman of the President's Commission on the Health Needs of the Nation, announced late in September that his 15-member group soon would submit an unbiased report of its activities and findings.

He commented that doctors were afraid that what came out would be socialistic and that a lot of the public were afraid it would not, but that in reality it would be a synthesis of 30 all-day panels held "on every imaginable phase of medical care" plus open hearings in every section of the country.

Dr. Magnuson warned that if physicians failed to furnish leadership in ascertaining health needs, "then another element in our society will take over." He further cautioned that "if organized medicine is to retain its rightful place of esteem in our society, it had better cease and desist at once from its current policy of proclaiming that it, alone, can decide whether there are any health problems in this country, and that it alone can decide what the average doctor

should think about the pressing problems of the day."

He declared that top people from the fields of labor, farm, industry and education, as well as medicine, had taken part in the commission's work with the result that "in more than 40 years of attending medical conventions and seminars, I have never seen and heard anything to approach these panels in free-swinging, democratic discussion of the problems in hand."

Citing a "hot and heavy discussion of the current shortage of clinical teaching beds for medical education," Dr. Magnuson emphasized that every member of the commission had declared against government control of whatever federal funds might go into medical education.

New Application Available for Priority Assistance

A new application form designed to aid business and government in obtaining special priorities assistance needed to expedite production has been issued by the National Production Authority, Department of Commerce.

The new form, NPAF-138 Revised, is entitled "Request for Priorities Assistance" and copies of it may be obtained at Department of Commerce offices or from the NPA in Washington.

To obtain special priorities aid, applicants must demonstrate clearly that the assistance is needed for the manufacture of a product or the rendering of a service essential to (1) a military or Atomic Energy Commission contract or program, or (2) to prevent serious delay in the completion of an important industrial, public utility or construction program, or (3) to carry out a program or activity essential to the health, safety or welfare of the community, or (4) to overcome an unreasonable, exceptional and proved hardship.

The effect of the action, the NPA said, is to make available for the first time a standard form on which an individual, firm, institution or unit of government may apply for priorities assistance to meet a special situation in which there is urgent need for delivery of material or equipment at a date earlier than is possible under normal delivery schedules.

The action also is expected to fill a long felt need on the part of both business and government for a public-use form which will indicate and provide the type of information required by NPA to enable the agency to take action on requests for assistance.

Hospitals Allocated 17,500 Tons of Steel

Allotments of structural steel for the first quarter of 1953 have been announced by the Defense Production Administration.

The allotments will allow continuation, in general, of all construction in the country already started but will permit only a limited number of new starts.

Ralph S. Trigg, DPA deputy administrator for Program and Requirements, pointed out that, with a few exceptions, allotments of structural steel are limited to the advance allotments previously made for the first quarter of 1953 and reflect the loss of steel production caused by the steel strike.

"Catching up with outstanding allotments of structural types of steel will take longer than with other types of steel because of the excessive backlog of structural orders already on the books at the time of the strike and because of the greater relative loss of production of structural steel," said Mr. Trigg.

For this reason, he said, the only new starts permitted in industrial expansion, commercial and municipal construction, will be those directly essential to the defense program.

For the first quarter of 1953, hospitals have been allotted 17,500 tons of structural steel. Allotments for the third and fourth quarter of 1952, respectively, were 24,800 tons and 19,540 tons.

Advisory Committee Reports on Use of Hospital Personnel

At the conclusion of a two-day meeting in October, O. G. Pratt, chairman, reported progress by the special task group of Health Resources Advisory Committee which is studying procedures for optimal utilization of hospital personnel—nurses, office help, domestic workers and others.

Mr. Pratt, who is executive director of the Rhode Island Hospital, Providence, stated that the task group expects to gather much needed information at the workshop to be conducted November 10-14 in Dearborn, Mich., under the auspices of the American Hospital Association. He said that the current study, which was inaugurated last spring, has accepted the following premises:

1. Governing bodies, administrators and the general public must recognize that the number of professional people available for hospital work is decreasing, and proportionately greater employment of nonprofessionals in the future is inevitable.

2. In many hospitals, professional skills are not used to the best advantage, and ways must be developed to promote better integration of professional and nonprofessional talents.

3. Creation of a total hospital team effort is essential, with no department functioning as an entity wholly independent of the others.

Veterans Administration to Ask for Additional Funds

Soon after it meets in January, Congress will be asked to restore a major part of the $31,000,000 which it slashed from the hospital and medical care programs of the Veterans Administration. This was made clear by Dr. Joel T. Boone, chief medical officer, when he spoke October 12 at the dedication of the $23,000,000 Veterans Administration general hospital at East Orange, N. J. Emphatic indorsement of Dr. Boone's remarks came from Carl R. Gray Jr., veterans administrator.

As a consequence of the drastic retrenchment, 2,250 employes of veterans hospitals throughout the country are being discharged, with November 4 as the separation deadline. The only staff personnel exempt from the cutback are physicians, dentists, nurses and dietitians. Some 92 hospitals are involved in the reductions.

At its quarterly meeting, held early in October, the Council of Chief Consultants to the Veterans Administration took cognizance of the medical department's financial crisis. It adopted the unusual step of making public a resolution, which urges the Veterans Administration either to demand supplemental appropriations or else shut down enough hospitals so that the remainder may operate with unimpaired efficiency. Otherwise, said the resolution, there is danger of "deterioration of service dangerous to the veteran-patient."

Hospital Council Takes Action on Hill-Burton Problems

At its October meeting in Washington, the Federal Hospital Council took action on a number of

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problems affecting Hill-Burton expansion.

Approval was given to the amendment of regulations permitting state agencies to extend special dispensation to construction projects whose financing is spread over two or more years and whose continuation is threatened by a project having a higher priority. Special consideration, which is discretionary with the state agency, may be given only if the project in question was approved before July 1, 1952.

The council also voted to require that public hearings be conducted annually on revision of state hospital plans, the purpose of this step being to give greater publicity to proposed changes.

In addition, the council initiated certain reforms relating to procurement of equipment for new hospitals and considered—but postponed final action—eligibility for Hill-Burton assistance of rehabilitation centers which are not affiliated with hospitals.

As of September 30, the Hill-Burton program score sheet stood as follows: Projects approved to date, 1,877, of which 1,033 are in operation; total estimated cost, $1,456,869,933, of which the federal share is $517,378,835. Authorized projects total 90,645 beds and 297 health centers, plus 61 health centers associated with general hospitals.

43 Hospital Projects Given "Go-Ahead" on Construction

The latest monthly report of the Division of Civilian Health Requirements, Public Health Service, reveals that in August 1952, a total of 43 hospital construction projects received "go-ahead" authorization under the government's controlled materials plan under which critical metals are allocated.

The 43 projects had a combined estimated cost of $19,831,550.

In the "more than $1,000,000" class were the following:

Danvers (Mass.) State Hospital medical and infirmary building, $2,417,325; Pottstown (Pa.) Hospital, 70-bed addition and nurses home, $2,200,000; Cleveland City Hospital, laboratory building, $1,550,000; Iredell Memorial Hospital (N. C.), new 100-bed hospital, $1,500,000; Langlade County Memorial Hospital (Wis.), 36-bed addition, $1,236,666; Traverse City (Mich.) Hospital, 100-bed tuberculosis unit, $1,183,260; Grace-New Haven Community Hospital, New Haven, Conn., school of nursing dormitory, $1,016,000.

Construction cost estimates include fixed equipment.

Bureau of Standards Issues Book on X-ray Protection

The National Bureau of Standards, which is a unit in the Department of Commerce, has published "Handbook 50" on x-ray protection design. The volume is intended to be of use particularly to architects and engineers planning hospitals, clinics and other institutions in which x-ray equipment will be used. H. O. Wyckoff and L. S. Taylor co-authored the handbook, which is purchasable for $.15 a copy from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Dr. Trautman Describes National Clinical Center

Dr. John A. Trautman, director of the Clinical Center of the National Institutes of Health, gave a detailed description of this 500-bed facility in an address September 30 before the District of Columbia Medical Society. Scheduled to admit its first patients in April 1953, the institution probably will be the largest, most modern and most completely equipped activity of its kind in the world.

The Clinical Center will be a central research facility for the National Cancer Institute, National Heart Institute, National Institute of Mental Health, National Institute of Dental Research, National Microbiological Institute, National Institute of Arthritis and Metabolic Diseases, and National Institute of Neurological Diseases and Blindness, all of which comprise the National Institutes of Health under the Public Health Service.

Patients will be obtained by referral from teaching institutions, private physicians, and public and private hospitals and clinics, said Dr. Trautman. The majority of them probably will come from eastern states. There will be no outpatient department.

"I should like to point out particularly," said Dr. Trautman, "that the Clinical Center is not a place set up for the study of bizarre or unusual diseases. Some of the latter quite obviously will be studied. The principal purpose of the Clinical Center, however, is to study those diseases that are responsible for the greatest number of deaths and disability among the people of this country. Since this is the situation, there should not be too great a problem in finding suitable clinical material, like the common heart conditions, mental diseases, cancer, the neurological diseases and blindness, arthritis, dental conditions, etc."

In mid-October, Surg. Gen. Leonard A. Scheele announced completion of plans for inaugurating a visiting scientist program at the National Institutes of Health and its Clinical Center. Research workers of demonstrated ability and specialized training will be invited to work at the Institutes in Suburban Bethesda, Md., for periods ranging from a few weeks to two years.

Changes in Indian Bureau

Two personnel changes in the Bureau of Indian Affairs have been announced by Acting Secretary of the Interior Vernon D. Northrop.

Robert D. Beasley, Chicago, has been appointed chief of the bureau's welfare branch, and Fred Massey, Washington, D. C., has been appointed chief of the budget and finance branch. Mr. Beasley succeeds Selene Gifford, Rochester, Mass., who was recently appointed assistant commissioner of the bureau. Mr. Massey succeeds Charles B. Emery who retired recently.

Public Health Service Offers 104 Medical Internships

Qualified men and women may apply for the 104 one-year medical internships at nine of the Public Health Service's hospitals. The internships will begin July 1, 1953. All applications will be received and processed in accordance with the procedures of the National Interassociation Committee on Internships.

To be eligible for medical internship in the Public Health Service, applicants are required to meet the qualifications for a commission in the Reserve Corps of the Service and must also express a willingness to remain with the Public Health Service for at least 12 months after completing the internship.

Interns in the Public Health Service are commissioned assistant surgeons, comparable with second lieutenants in the Army.

The Public Health Service's hospitals offering intern training are at Baltimore, Md.; Boston; Norfolk, Va.; New Orleans; San Francisco; Seattle, Wash.; Galveston, Texas; Cleveland, and Staten Island, N. Y.

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Health Service internship may obtain further information by writing the Committee on Residencies and Internships, Federal Security Agency, Public Health Service, Washington, D. C.

Federal Institutes Graduates Form Associatiton

Graduates of the Federal Inter-Agency Institutes for Hospital Administrators have voted to form an association, to be called the Association of Federal Inter-Agency Institute Administrators. The action was taken at a meeting of the graduates during the American Hospital Association convention September 16 in Philadelphia.

A committee has been appointed to write up a constitution and by-laws for the new organization. Members are Reuben Cohen, Col. Levi M. Browning, Capt. Harold G. Young, Dr. James A. Shaw, Dr. Max Van Sandt, Pierre Palmer and Col. Thom McGibney.

Col. Frederick H. Gibbs of the Brooke Army Medical Center, Fort Sam Houston, Texas, was elected first president of the group. Other new officers are: First vice president, Dr. John A. Trautman, director, National Institutes of Health, Public Health Service, Bethesda, Md.; second vice president, Capt. Gerald M. Smith, commanding officer, U. S. Naval Hospital, Philadelphia; secretary, Dr. Lee H. Schlesinger, manager, Veterans Administration Hospital, Clarksburg, W. Va., and treasurer, Dr. Max Van Sandt, Health Branch, Bureau of Indian Affairs, Interior Department, Washington, D. C.

Bennett Chapple Appointed Assistant Administrator to NPA

Bennett S. Chapple Jr., Pittsburgh, has been appointed assistant administrator of the National Production Authority, Department of Commerce, in charge of the Metals and Minerals Bureau, it has been announced by NPA Administrator Richard A. McDonald.

Mr. Chapple succeeds William M. Day, Detroit, who has returned to his former position in private business.

The Metals and Minerals Bureau is composed of six operating divisions: Iron and steel, aluminum-magnesium, the combined tin-lead-zinc and miscellaneous metals and minerals; copper, and salvage.

VA To Admit Patients on New Priority Basis

Eligible veterans will be admitted to Veterans Administration hospitals on the basis of nine new priority groups, the Veterans Administration announced recently.

The nine priority groups are based on laws enacted by the Congress and administered by the agency. The groupings are designed to establish an equitable rule governing the use of vacant beds for all persons eligible for admission or transfer to a particular veterans hospital under these laws.

Excluding emergency admissions, all eligible persons will be admitted in the following order of priority:

Group 1—War veterans and those who served since June 27, 1950, who require hospitalization for service-connected disabilities.

Group 2—Peacetime veterans requiring hospitalization for service-connected or line of duty discharge disabilities.

Group 3—Veterans whose hospitalization has been requested by authorized officials for observation and examination purposes.

Group 4—Wartime, post-Korea, and peacetime veterans with service-connected disabilities or with line of duty discharges who are now hospitalized by Veterans Administration or non-Veterans Administration hospitals, but who have requested transfer to a Veterans Administration hospital.

Group 5—Wartime, post-Korea, and peacetime veterans who are now hospitalized by the Veterans Administration for treatment of nonservice-connected disabilities, but whose transfer from one hospital to another has been requested by authorized officials for medical reasons.

Group 6—Wartime, post-Korea, and peacetime veterans with compensable service-connected disabilities or discharged for line of duty disabilities requiring hospitalization for nonservice-connected disabilities.

Group 7—Wartime, post-Korea, and certain veterans retired from the U. S. Armed Forces for physical disabilities, having no compensable service-connected disabilities and not discharged for line of duty disabilities, who require hospitalization for nonservice-connected disabilities.

Group 8—Nonveterans whose hospitalization has been requested by authorized officials, excepting U. S. Armed Forces personnel whose hospitalization is directed by the Veterans Administration Central Office in Washington, D. C.

Group 9—All eligible veterans currently hospitalized in another veterans hospital who have requested transfer for personal

THE AMERICAN COLLEGE OF SURGEONS' outgoing president, Dr. Alton Ochsner (left), New Orleans, congratulates the college's new president, Dr. Harold L. Foss, of Danville, Pa., during the 38th annual clinical congress of the group September 26 in New York City. Dr. Foss is wearing a medallion symbolic of his new position as president of the college.

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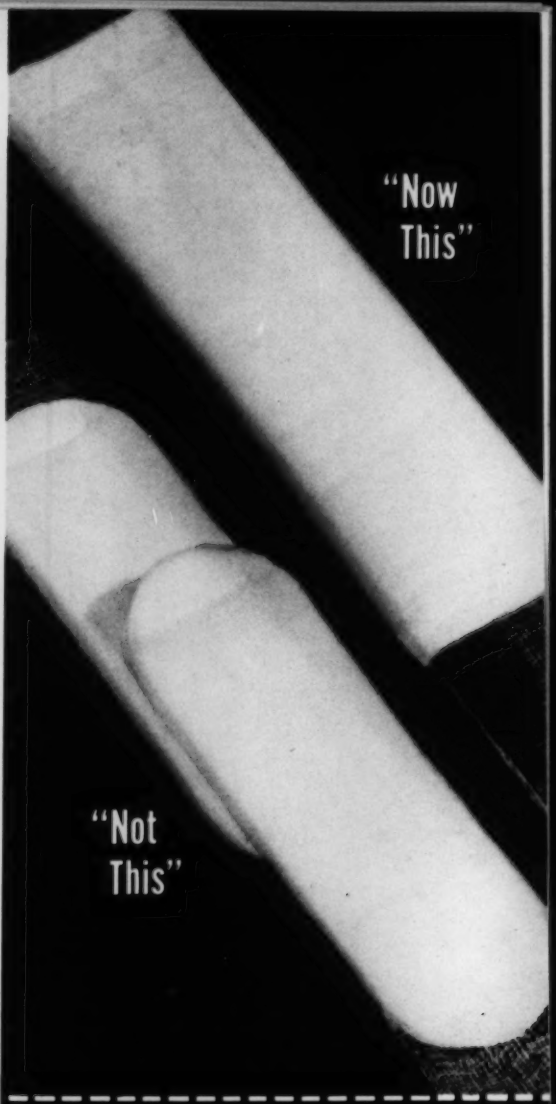

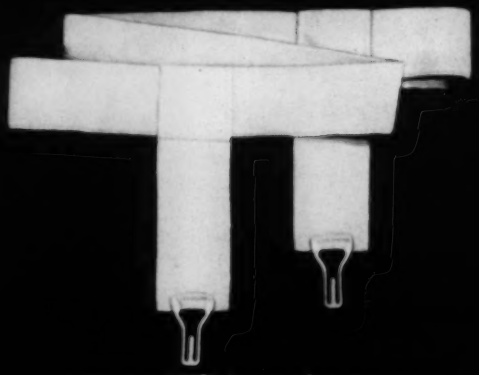

and this New KOTEX Hospital Belt does away with costly, old-fashioned T-binders

reasons, but whose transfer is not necessary for medical reasons, and certain eligible veterans whom the Veterans Administration has hospitalized in non-Veterans Administration hospitals and who have requested transfer to veterans hospitals for personal reasons but whose transfer is not necessary for medical reasons.

PHS To Develop Program for Training Nurse Aides

The Public Health Service's Division of Nursing Resources, is developing a program of instruction for hospital nurse aides which, when completed, will be made available to hospitals throughout the United States.

The project was undertaken at the request of the Health Resources Advisory Board as a means of increasing the number of trained nonprofessional nursing personnel employed by hospitals. It is being jointly sponsored by the American Hospital Association and the National Committee for the Improvement of Nursing Service.

The program calls for the preparation of a manual of procedures for use by nurse aides, a guide for instructors, and the introduction of these materials through teaching institutes in large and small communities. The Public Health Service and the National Committee for the Improvement of Nursing Service will sponsor the institutes. The American Hospital Association will publish the training manual.

World Medical Association To Award New Trophy

A trophy for the most outstanding medical achievement during the year will be awarded each year by the World Medical Association. The first award probably will be made at the Seventh General Assembly of the association in Amsterdam, Holland, in 1953. The announcement was made by Dr. Louis H. Bauer, secretary general of the World Medical Association.

To be donated by Walter Donald Ross of Vancouver, B. C., it will be known as the Walter Donald Ross Perpetual Trophy.

Provisions regarding the presentation of the award were drafted during the meeting of the Council of the World Medical Association October 18-19 in Athens, Greece.

· · ORGANIZATIONS · ·

Public Health Doctors May Organize

A plan to form an American Association of Public Health Physicians was offered for consideration by the executive committee of the American Public Health Association at its meeting late in October.

The movement, indorsed and approved by the American Medical Association's Board of Trustees several months ago, was promoted by the following committee: Dr. Bruce Underwood, Louisville, chairman; Dr. Wilson T. Sowder, Jacksonville, Fla.; Dr. Grady F. Mathews, Oklahoma City; Dr. R. C. Williams, Atlanta, Ga.; Dr. S. J. Phillips, New Orleans, and Dr. Frank E. Wilson, Washington, D. C.

The committee hopes to have the indorsement and active sponsorship of the Association of State and Territorial Health Officers.

A statement issued recently by the committee says:

"The general purpose is to provide an Association of American Public Health Physicians to which the public health physicians in local and state and territorial health departments may belong. We feel there is a need for an American Association of Public Health Physicians. At the present time, there is no single agency or group which can officially speak for the public health physicians of this country. The American Medical Association primarily represents the practitioners of medicine; the American Dental Association represents the dentists; the American Hospital Association represents the hospitals; the American Psychiatric Association represents the psychiatrists, and there are many other associations which represent various health and medical professions; but there is none that adequately represents the public health physicians.

"The American Public Health Association has a section for health officers, but the association includes a majority of nonmedical persons and, for this and other reasons, the association cannot, by its very nature, speak adequately for the doctors of medicine engaged in preventive medicine and public health.

"The Association of State and Territorial Health Officers does not include district or local public health physicians. Neither can the Conference of State and Provincial Health Authorities of North America, for the same reasons, represent all physicians engaged in preventive medicine and public health."

The committee declared that all public health physicians in the country should belong to and participate in the American Medical Association and the American Public Health Association. In addition, it said, they need an association limited to doctors of medicine in the field of preventive medicine and public health. The purpose of the association, it continued, would be to foster and maintain leadership consistent with the ethical standards and fraternal desires of the public health physicians.

New Organization Formed for Hospital Executives

A new organization called the Hospital Building Service Directors Association was formed by executives in that field at a charter meeting in September at Mount Sinai Hospital of New York, New York City.

The group adopted a four point pledge of purpose and announced that after an organization period ending January 1, membership applications would be welcomed from hospital executive housekeepers and building service directors in New York, New Jersey and Connecticut. The group plans to expand to national status eventually.

The association announced that it would seek to: (1) Serve as an exchange of information for members and all hospital executives; (2) strive for recognition equal to other professional hospital services for its members; (3) explore and help institute a program of employee training, and (4) help to achieve national standardization of equipment, procedures and executive titles.

The following officers were elected: President, Theodore E. C. Warren, New York Hospital; vice president, Myrtle Ryder, Mount Sinai Hospital of New York; secretary, Herbert J. Harte, Veterans Administration Hospital, Bronx, N. Y., and treasurer, George Spicer, Montefiore Hospital, New York.

Members of the executive board, all in New York City, are: William J. Cain, Roosevelt Hospital; Pauline Jerome, New York Department of Hospitals; M. L. Jolly, Doctors Hospital; Harold Liscombe, Columbia-Presbyterian Hospital, and Catherine W. Stevens, New York Hospital.

New Pamphlets Explain Some of Health Problems

Two pamphlets to help create a better public understanding of some of the health problems of today have been prepared by the American Medical Association.

"Your Money's Worth," designed to explain the cost of illness to the general public, deals with the medical bill, the hospital bill and the drug bill. It concludes by saying that everyone has money worries these days, but that the public should remember a few points about bills for medical care: "Doctor's fees haven't gone up as far—or as fast—as your other family expenses. You put in less work to pay your medical bills than ever before. You spend the same proportion of your budget on medical costs as your parents did 20 years ago. Finally, health progress is giving you a mighty important dividend—more and better years in which to earn your living and to enjoy life."

The second booklet, "Winning Ways," serves as an office guide for doctors and their assistants, pointing out the way to mutual understanding between the doctor and his patients.

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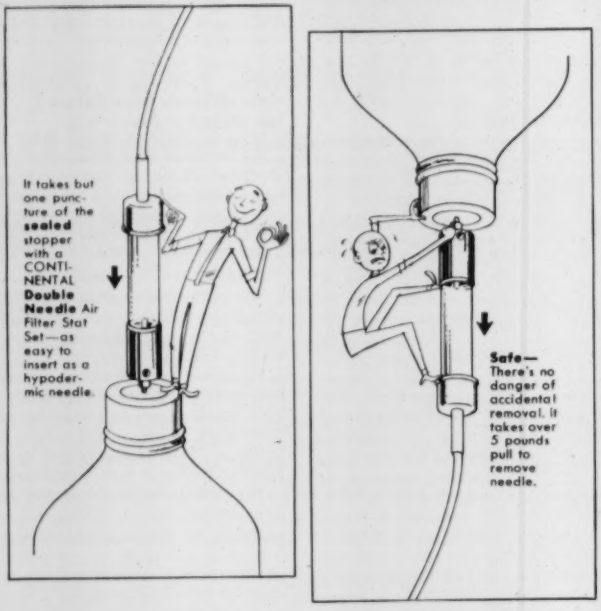
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Osteopaths Invited to Practice in Waynesville, Mo., Hospital

Osteopathic physicians have been permitted to practice in the Pulaski County Hospital at Waynesville, Mo. Previously, the hospital staff has been limited to medical doctors.

The board of directors of the hospital invited members of the Central Ozark Osteopathic Association to become staff members of the hospital and the osteopathic physicians accepted the invitation.

Dr. W. M. Cottingham, president of the Central Ozark Osteopathic Association, said that the osteopathic physician will enjoy full rights and privileges of the hospital.

Dr. Bauer Charges Truman With Mistaken Ideas

The American Medical Association's president, Dr. Louis H. Bauer, was quick to reply to President Truman's press conference remark that the American Medical Association was abandoning its fight against socialized medicine now that Clem Whitaker and Mrs. Leone Baxter Whitaker had resigned as lobbyists against compulsory health insurance.

The medical association announced that the assignments of the two had ended and that they planned to take over the organization of a National Professional Committee for Eisenhower and Nixon.

The President told the press that he had the impression that the American Medical Association was giving up and acceding to his demands for a national compulsory health insurance program. He also said he thought his speech on medical care during the American Hospital Association convention caused the disbanding of the lobby committee against his national health program.

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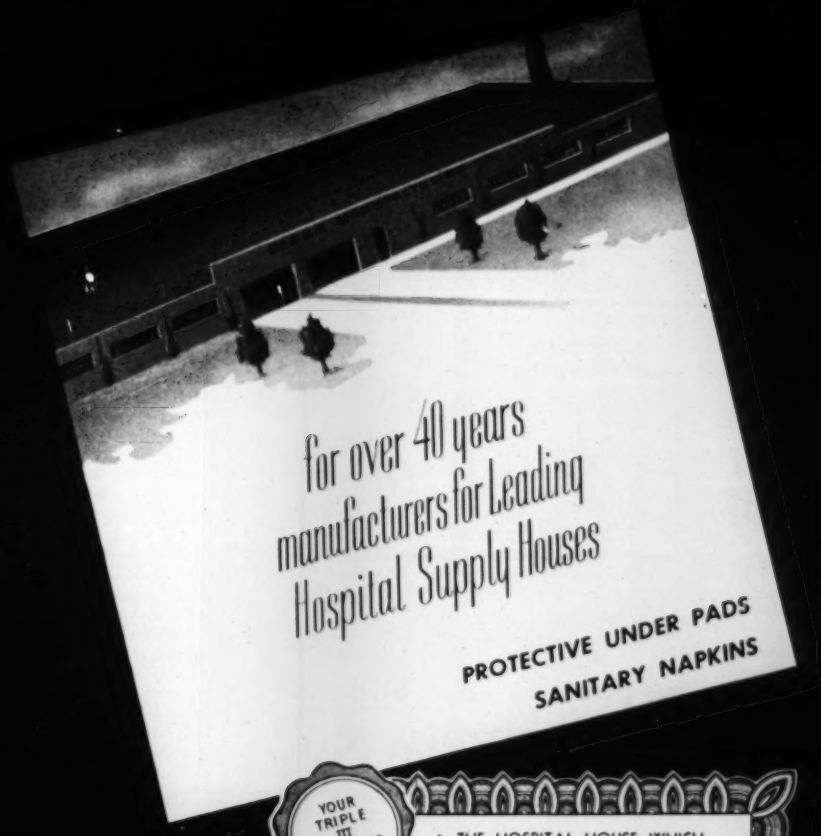

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Dr. Bauer's statement to the press said that Mr. Truman had some mistaken ideas about the American Medical Association's giving up.

"The American Medical Association will never cease its fight against national compulsory health insurance," the statement said. "Mr. Truman's Philadelphia speech had no bearing whatsoever on the decision to disband a special committee set up to conduct an intensive short-term, educational program against socialized medicine. This decision was reached by the American Medical Association's House of Delegates last June, and was widely publicized at the time.

"The National Education Campaign was merely one intensive phase in the medical profession's long range effort to keep medical care on a voluntary basis. This effort will continue as long as attempts are made to shackle the people's health in bureaucratic red tape.

"Mr. Truman is naive indeed if he believes that any speech he delivers could change the medical profession's basic beliefs concerning high quality medical care."

Advisory Committee Approves U.M.W.A. Medical Program

General approval of the medical care program of the United Mine Workers Welfare and Retirement Fund, including plans for constructing 10 hospitals, has been given by the Medical Advisory Committee of the fund.

The committee is made up of seven nationally outstanding specialists and practitioners with long experience in the type of public health and rehabilitation measures found necessary in mining areas.

They are: Dr. Robin C. Buerki, executive director of the Henry Ford Hospital, Detroit, chairman; Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation, New York City; Dr. Carl M. Peterson, secretary of the Council on Industrial Health, American Medical Association; Dr. Walter E. Vest, Huntington, W. Va.; Dr. William W. Haggart, Denver; Dr. Harold S. Diehl, dean of the medical sciences, University of Minnesota School of Medicine, and Dr. Dean A. Clark, general director, Massachusetts General Hospital, Boston.

The committee members showed especial interest in the rehabilitation services of the fund and recommended that rehabilitation facilities be included in the new hospitals, so far as space would permit.

The committee also emphasized the importance of developing outpatient services in connection with the hospitals, and to the fullest extent possible. The members felt that such services should provide a dynamic approach to medical service and are an important factor in limiting the necessity of hospitalization in many instances.

New England Hospital Assembly Sponsors Traveling Workshops

As a new service to hospitals in New England, the New England Hospital Assembly is making available to state hospital associations traveling faculties who are prepared to conduct one-day workshops on accounting, personnel practices and purchasing.

The workshops are designed for presentation to small groups who will not be expected to travel more than 50 miles to the workshop center. The basic approach to the one-day workshop is to present to ad-

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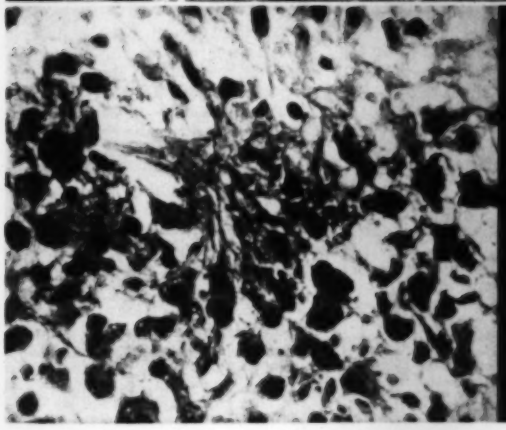
response in rheumatic fever

q. Does cortisone influence the heart lesions of rheumatic fever?

a. Early cortisone administration suppresses and in some cases may even prevent serious cardiac damage.



q. What effect does cortisone have on acute rheumatic fever?

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ministrators and department heads practical procedures that can be readily applied in hospitals with less than 150 beds. Many of the procedures to be presented will also apply or can easily be adapted to large hospitals, the assembly reports.

Each workshop is designed to begin at 10 A.M. and close at 4 P.M. The morning and afternoon sessions each will be two and one-half hours long. Any hospital that is a member of its state hospital association, upon payment of a $5 fee, will be entitled to send as many persons to a workshop as it believes will benefit by such attendance.

Each state hospital association, through its president, may request a session of the traveling workshop to be held either in one location, or on successive days in two or three locations. It is suggested that the workshop be held at a centrally-located hospital.

New England hospitals that are interested in securing more complete information about any of the three one-day workshops may obtain the information from the secretary of the New England Hospital Assembly, Richard T. Viguers, New England Center Hospital, Boston.

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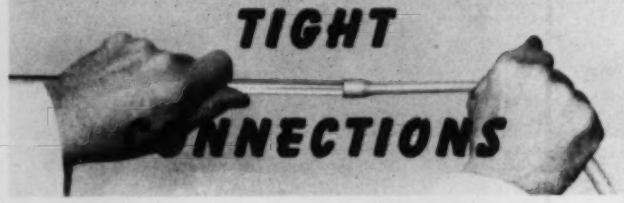

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Montana Association Elects 1953 Officers

Harry C. Dunham, administrator of Memorial Hospital of Western Montana, Missoula, was elected president of the Montana Hospital Association during its annual conference early in September.

Sister Mary Bede was named president-elect. She is administrator of the Columbus Hospital, Great Falls. Trustee for another four years is Sister Mary Anthony, administrator of the Kalispell General Hospital. Edwin Grafton, administrator, Shodair Crippled Children's Hospital, Helena, was re-elected secretary-treasurer.

Correction

The joint meeting of the American Association for the Advancement of Science and the American Association of Hospital Consultants will be held on December 28 at Kiel Auditorium in St. Louis. On page 162 of HOSPITALS for October, it was erroneously reported that the meeting would be held December 29.

Dr. Frank R. Bradley, director of Barnes Hospital in St. Louis, will be chairman of the joint meeting.

Clifford Dahl Re-elected Head Of Nursing Homes Association

The American Association of Nursing Homes concluded its third annual convention September 29 to October 1 in Chicago by re-electing Clifford Dahl, Wayne, Neb., as president.

Registration at the convention totaled 500, representing 25 states. The program covered all aspects of the care of aging people and the problems involved in conducting nursing homes. Among the speakers at the three-day meeting were Dr. Karl Menninger, educational director for the Menninger Foundation, Topeka, Kan. His subject was geriatric psychiatry.

Included in the program was a panel discussion on nursing home problems. Participants were Dr. Charles J. Thill, Stritch School of Medicines, Loyola University, Chi-

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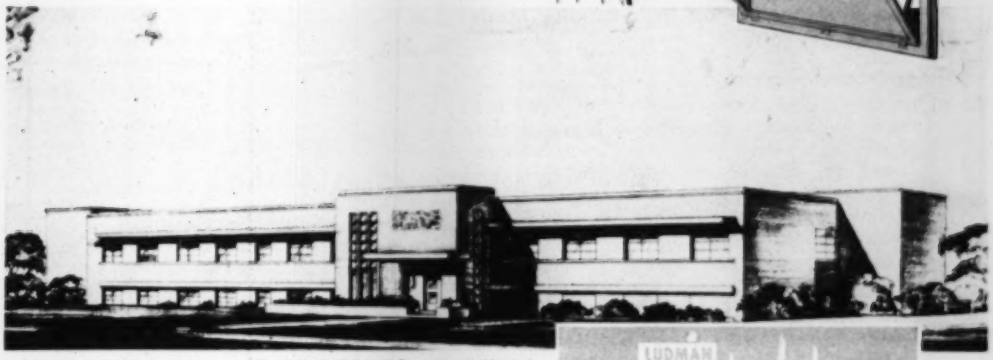

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No more stuffy, humid rooms when it rains. The rain can't come in through Auto-Lok's slanting vents! In cold weather they keep the heat in and the cold out...save enough in heating costs to pay for themselves over and over again. In warm weather they open widest to catch every breeze, but no drafts...or, close tight to conserve air conditioning.

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ALUMINUM WINDOWS
For Your Hospital

Tightest closing window ever made!
Seals itself shut like the door of a refrigerator!

Special nite vent!
Can remain slightly open to admit fresh air, while upper vents are closed and locked.

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cago; J. E. Millizen, superintendent of the University of Illinois Research and Educational Hospital, Chicago; Theda Waterman, R. N., executive director of the Central Agency for the Chronically Ill, Milwaukee; Edward M. Tracewell, attorney, Kansas City, Mo., and Mrs. Louise Moody, nutritionist, Illinois Department of Public Health, Chicago.

Other speakers were Dr. John H. Rogers, Chicago, executive director of the Illinois Division of the American Cancer Society; Margaret Ranck, R.N., consultant nurse, Nursing Homes of Illinois; Edna Nicholson, director, Central Service for the Chronically Ill, Chicago, and Dr. Cletus L. Krag, officer in charge, Public Health Service, Washington, D. C.

Other officers elected at the convention were: First vice president, Adele Pearson, Minneapolis; second vice president, Frances Barclay, Berea, Ohio; third vice president, Zilpha Morgan, El Paso, Ill.; secretary, George T. Mustin, Memphis, Tenn., and treasurer, Clebern S. Edwards, Stoneham, Mass.

Here is what happens in your hospital when you Standardize on the Standby Model . . .

DOCTORS AND NURSES find the Standby easy to use—they can read the Exactilt scale instantly whether standing or seated. The Standby neatly fits any location where bloodpressure is measured—is never in the way in wards, operating rooms and outpatient departments.

STAFF CHIEFS are sure that bloodpressure readings are exact—for every Baumanometer is a true mercury gravity instrument, individually calibrated and guaranteed to be scientifically accurate and to remain so.

MAINTENANCE ENGINEERS are happy because replacement of parts and repairs have been minimized. They like the sturdy die-cast magnesium and aluminum construction, the completely recessed and resiliently mounted cartridge tube, and all the other rugged features of the Standby.

THE HOSPITAL ADMINISTRATOR, the man who pays the bills, knows that to standardize is to economize. Buying and record-keeping are easier and a single type of bloodpressure equipment serves all hospital needs.

Try the Standby Model in operating rooms, wards, outpatient departments...Call your regular distributor of Baumanometers—he will be glad to deliver an additional Standby for your free trial.

Lifetime Baumanometer

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Since 1916 Originator and Maker of Bloodpressure Apparatus Exclusively

R. C. Magee Named President Of Wyoming Association

Rex C. Magee, administrator of the Memorial Hospital of Sweetwater County, Rock Springs, was elected president of the Wyoming Hospital Association at its annual meeting September 26-27 at Rock Springs.

Other officers elected at the two-day meeting are: Vice president, Charles D. D'Spain, administrator of the Cody Hospital, and secretary-treasurer, Sister M. Margaret, superintendent of the Weston County Memorial Hospital, Newcastle.

New England Inaugurates "How We Do It" Contest

The New England Hospital Assembly is accepting entries for its new "How We Do It" contest. Finalists in the contest will be selected during a special session of the New England Hospital Assembly's convention next March.

The contest, which is similar to that inaugurated by the American Hospital Association, gives credit to the imaginative worker or administrator for time or money-saving ideas that have proved effective, and makes the ideas available to other hospitals.

Entries, to be submitted not later than December 15, must include a complete description of the idea or technique, together with any illustrations which would clarify the written material. Winners of the contest will receive a $50 U. S. Savings Bond.

Entries should be submitted to: "How We Do It Contest," c/o Miss Abbie E. Dunks, 25 Bennet St., Boston 11.

Chicago Announces Plan To Cut Infant Mortality

The Chicago Board of Health has made public its "Chicago Plan" for reducing the number of babies who die in their first month. Such early deaths have occupied the attention of health department physicians, scientists and researchers for the last 15 years.

The plan calls for:

1. A close check by city health officers on all deaths in infancy.

2. More accurate means of determining the causes of such deaths.

3. Tracing of influences on an expectant mother due to her race,

Specialists in Maintenance Cleaning Products

TAKE YOUR PICK

Here are two superior Wyandotte cleaners for floors, walls, painted surfaces—one ALL-SOLUBLE, one MILDLY ABRASIVE!

F-100

WYANDOTTE F-100* dissolves quickly and completely . . . rinses freely. Just two ounces make one gallon of powerful cleaning solution, giving you great savings over comparable quality cleaners. F-100 is ideal for wood and asphalt-tile floors . . . excellent for washing painted surfaces, waxed floors (4 ozs. per gallon for *de*waxing floors). No films, no harm to the skin with all-soluble F-100!

DETERGENT

Mildly abrasive WYANDOTTE DETERGENT is especially effective on marble, porcelain, mosaic and tile. With scrubbing machines, DETERGENT means real savings . . . often more than pays for itself through brush savings alone! DETERGENT contains CARBOSE*, WYANDOTTE'S amazing sodium CMC, which ups cleaning power 50% to 80%. If your choice is a mildly abrasive cleaner, try DETERGENT!

For these products call in your WYANDOTTE representative or supplier. Also, he'll show you non-slipping WYANDOTTE WAX and other fine products for maintenance cleaning. *Wyandotte Chemicals, Wyandotte, Michigan.*

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Helpful service representatives in 138 cities in the United States and Canada.

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Largest manufacturers of specialized cleaning products for business and industry

living conditions or environment that might cause infant death.

4. Use of such information on known infant deaths to reduce the number of other deaths.

In the Board of Health's report, it was charged that too many health authorities have done "too little, too late, for too few" in reducing infant mortality. The report pointed out that pregnant women in the lower income brackets accounted for about a third of all preventable infant deaths. It also blamed faulty hospital procedures and health department deficiences for others.

The report showed that Chicago had its lowest maternal death rate in history during 1951. The new low record was one death in every 2,500 live births, compared with one in every 1,650 the year before.

Seminar-Workshop Planned for Record Librarians

A three-day seminar and workshop for medical record librarians will be conducted by the St. Louis University School of Nursing throughout the midwest January 22-24.

The seminar and workshop are being offered in response to requests of hospital administrators and medical record librarians in Missouri, Illinois and other midwestern states. The lectures will cover the major functions of a medical record librarian. Several lectures will be devoted to standard nomenclature of diseases and operations.

Lecturers during the three-day program will include Sister Mary Servatia, director of the department of medical record library science, St. Louis University; Sister Mary Yvonne, instructor in medical record library science at the St. Louis University School of Nursing; Betty Jane Beffa, St. Mary's Hospital; Viola Cheney, Barnes Hospital; Patricia Jeffrey, Labor Health Institute; Laura Koetting, St. Louis City Hospital; Rozene McClelland, Missouri Baptist Hospital; Sister Mary Sylvia, St. Mary's Hospital, and Marie Zimmerman, Barnes Hospital. All of the participants are registered record librarians and represent St. Louis institutions.

12,000 Rehabilitated Disabled Removed from Relief Rolls

One of every five disabled men and women who were rehabilitated into successful employment by the state-federal system of vocational rehabilitation during the past fiscal year was taken from public assistance rolls, announced Federal Security Administrator Oscar R. Ewing.

The group has been receiving approximately $8,500,000 a year in public assistance and is expected to earn an aggregate of $22,500,000 this year, Mr. Ewing said.

A check by the Federal Security Agency revealed that 63,632 disabled civilians were rehabilitated and that more than 12,000 of these were public assistance recipients at the time they were accepted for rehabilitation.

Disabled parents in families receiving aid to dependent children numbered 5,200; aid to the blind accounted for 1,200; another 800 were receiving aid to the permanently and totally disabled; approximately 400, old-age assistance; 4,000, general assistance, and approximately 300, unspecified aid.

The 20 per cent of rehabilitated public assistance recipients was the highest ever recorded and was substantially above the total of the preceding year when 7,957, or 12 per cent, of those rehabilitated were removed from public assistance case loads.

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Sterile... BARDIC Disposable Plastic Drainage Tubes are packaged sterile in individual boxes ready for immediate use.

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UNITED STATES CATHETER and INSTRUMENT CORP.

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BRAND OF ALKAVERVIR

treats the patient

by inducing

- **PROMPT SYMPTOMATIC RELIEF**
- **GREATER STAMINA**
- **IMPROVED SENSE OF WELL-BEING**

The patient receiving Veriloid experiences prompt relief of the very symptoms which caused him to seek professional care. Shortly after dosage adjustment is completed, headache and malaise are greatly reduced in severity or disappear entirely, and a sense of well-being quickly develops. This subjective improvement usually precedes a significant fall in blood pressure.

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LOWERING THE BLOOD PRESSURE

Through central action, Veriloid produces a gratifying drop in arterial tension in a significant percentage of patients treated. A unique, highly purified fraction of Veratrum viride, Veriloid is indicated in all grades of essential hypertension. The average patient requires from 9 to 15 mg. daily in divided doses.

Veriloid (brand of alkavervir) is available on prescription in 1 mg., 2 mg. and 3 mg. tablets.

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Personnel Study To Be Published

The American Hospital Association will underwrite the cost of preparing a booklet on an experiment in personnel efficiency being conducted by Harper Hospital, Detroit.

The Board of Trustees recently approved $6,000 for expenses involved in writing the manuscript covering the study that has been going on under the direction of George E. Cartmill Jr., director, and Marion J. Wright, R. N., associate director of the hospital.

Basically, the experiment consists of a complete evaluation of all the factors involved in patient care, with emphasis on the hospital's use of and need for personnel, both in the nursing service and elsewhere. From the study, the hospital is developing a system to enable it to use its personnel with the greatest amount of efficiency and economy.

Miss Wright points out that such an evaluation must include the entire hospital, not just the nursing service. She also warns that "no plan can be tailor-made to fit all institutions."

One of the results of the study is a plan for dividing work and responsibilities between professional personnel. Routine duties that were being done by graduate nurses in the hospital were turned over to practical nurses or nurse aides so that the graduate could spend more time giving bedside care and doing medications and technical treatments.

The hospital set up a test based on the statistical analysis it had made. Many housekeeping functions were taken away from nurses and given to housekeeping. Dietary maids were given the task of delivering trays to patients, thereby relieving nurses of the duty.

A pharmacy delivery system was set up which was found to save 68 man-hours a week. No extra pharmacy help was hired. A central messenger service was developed to run all errands and transport all patients anywhere they were to go except to the operating room. These trips, approximately 1,400 a week averaging from 5 to 30 minutes each, previously had been made by floor personnel. Finally, nursing duties were delegated to supervisors, graduate nurses, practical nurses and nurse aides according to the training and ability of each.

The manuscript when completed will be published by arrangement with the American Hospital Association and will be available to other hospitals.

United States Hospitals Report Rate Increases

Charges in hospitals have increased during the last year, the American Hospital Association reports in its sixth annual study of hospital rates in general hospitals of the United States.

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DEODORANT
SPRAY
let the light, fresh fragrance of a woodland bouquet greet your guests, soothe your patients, and create a more pleasant working atmosphere for your staff. . . . spray regularly throughout your hospital to combat unpleasant odors . . . let Midland DEODORANT SPRAY pay its subtile floral tribute to your sense of hospitality.
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A catalog showing the complete Polar Ware line is yours for the asking.

a long return on a small investment

GRANTED that a bed pan is a bed pan — there's still a difference in your favor between the service potential of stainless steel Polar Ware and others.

Take hold of a Polar Ware pan. You'll notice at once that it "feels" stronger, more rugged. And it *is* more rugged . . . made of heavier gauge stainless steel that will still be in every-day use long after ordinary lighter gauge pans have been replaced.

It's good to know, too, that the most advanced welding process makes this better bed pan in one solid piece. The inside has a satin-smooth surface. There is no area that can harbor bacteria, no concealed section that ordinary aseptic methods will not make sterile.

In large and small hospitals everywhere, the economical, trouble-free performance of this Polar Ware pan is being proved every hour of the day. You, too, will find it premium in everything but price. Ask the men who call on you. The best of them carry Polar Ware.

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The average of the most common daily room rates in 1952 in all United States general hospitals was $12.23 for a single room, $9.68 for double room and $8.24 for multi-bedroom. These rates are approximately 7 per cent higher than in 1951 and more than 40 per cent higher than those in 1947.

Charges for operating rooms, diagnostic tests and therapeutic treatments are gradually increasing although the most frequent rate has remained fairly constant for the past six years. The per cent of hospitals, the survey reveals, that charge $20 or more for use of the operating room for appendectomies increased from 27 cent in 1947 to 65 per cent in 1952. Also, the number of hospitals charging $15 or more for the use of the operating room for tonsillectomies increased from 9 per cent in 1947 to 31 per cent in 1952.

In the 1952 study, 47.2 per cent of the reporting hospitals stated that charges for anesthesia were established and made directly to the patient by the hospital; 31 per cent, by private physicians, and 3.3 per cent, by other means.

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SIMPLE TO
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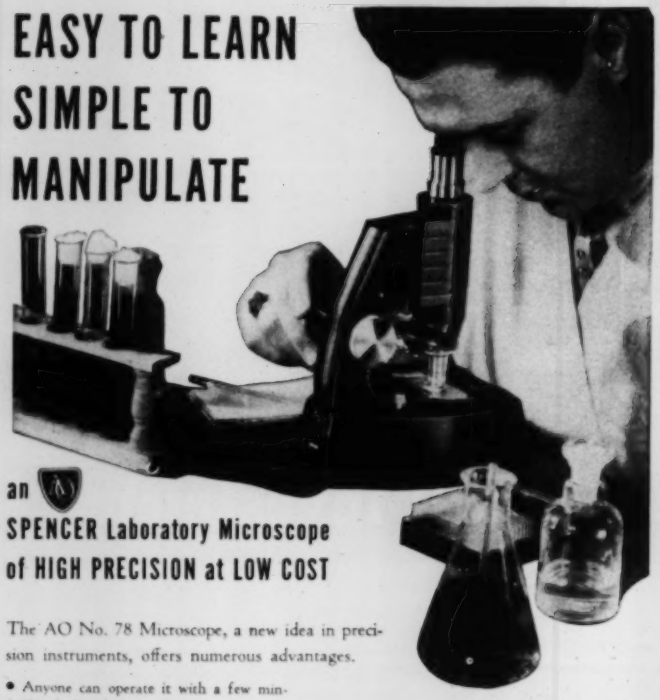

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The AO No. 78 Microscope utilizes the same high quality optics and precision-built mechanical parts that have won world recognition for higher priced AO Spencer Microscopes. If you have not already studied its time and money-saving advantages, see your AO distributor or write Dept. L200.

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Hospitals generally are favoring more and more separate charges on each laboratory test rather than adhering to an all-inclusive rate, or a standard charge for routine laboratory tests. In 1952, more than 60 per cent reported separate charges.

Charging for the care of newborn during the mother's stay is now a reported practice by 85 per cent of the hospitals, an increase over the 75 per cent reported six years ago.

Little change was observed in hospital policy from 1947 through 1952 concerning charges for drugs carried in stock on the nursing unit. About 80 per cent of hospitals having less than 50 beds make such charges, as compared to about 40 per cent of hospitals having 250 or more beds.

More than 70 per cent of the hospitals have only one rate on special services which applies to all patients irrespective of type of room occupied or financial status of the patients. Less than 10 per cent have two and three rates which are charged according to type of accommodation used by the patients. Compared with data of five years ago, the one rate system seems to be gaining in practice.

Receipts from governmental agencies for care of indigent patients have increased during each of the past six years. The 1952 average was $10.93.

Data from 1,780 hospitals answering the question on the per cent of patient days for which some agency assumed all or partial liability indicate that Blue Cross accounts for about 33 per cent of the patient days; commercial insurance, 18.8 per cent; governmental agencies, 7.8 per cent, and that the remainder, 40.3 per cent, are the full responsibility of the patients themselves. The figures indicate that the large hospitals serve slightly more Blue Cross and commercial insurance patients than small hospitals, and nonprofit hospitals more than proprietary or governmental hospitals.

Hospital Construction Progresses Under CMP

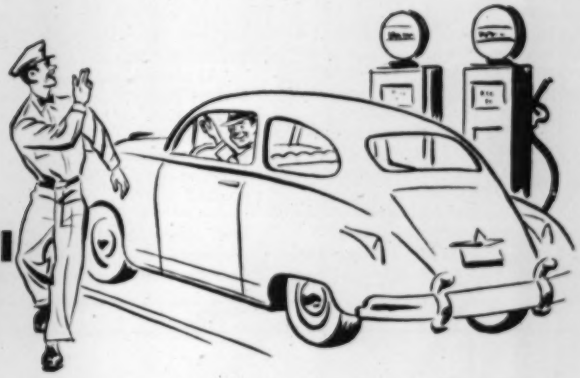
Hospital construction fared well during the first year of the federal Controlled Materials Plan, and the outlook for the coming 12-month period is bright, reports the American Hospital Association.

The rate of new hospital construction, in spite of tremendous

"SEE YOU AT THE POLLS!"

"SEE YOU AT THE POLLS!"

"SEE YOU AT THE POLLS!"



Nobody knows for sure how it started—this line about "See you at the Polls!" we're hearing all over these days.

Best explanation seems to be that it came from that state candidate out west. . . . His opponent in a debate got all riled up and challenged him to fight it out in the alley.

But he said—"I'll settle this the AMERICAN way—I'll see you at the polls!" And the audience picked up the chant.

Now everybody's saying it—and on Nov. 4 everybody will be *doing* it!

"SEE YOU AT THE POLLS!"

"SEE YOU AT THE POLLS!"

HOSPITALS
Journal of the American Hospital Association

gains, is still not up to the demands for new facilities. Estimates for the 1952 volume of hospital and institutional construction show, for the third successive year, expenditures in excess of $800,000,000 (as reported jointly by the U. S. Department of Commerce and the U. S. Department of Labor).

Hospital construction is expected to be about 7 per cent below last year's record volume of $916,000,000, but still greater than the second best year—1950—when expenditures totaled $820,000,000. Major advances will be seen in expenditures for military and defense facilities and atomic energy projects.

The following table shows the increase in hospital construction expenditures since 1940:

1940	$ 87,000,000
1944	84,000,000
1948	349,000,000
1950	820,000,000
1951 (estimate)	916,000,000
1952 (forecast)	850,000,000

A total of 1,150 existing hospitals (out of 6,832 surveyed) reported plans to put an additional 79,812 hospital beds in operation during 1952 as the result of new construction or remodeling, according to statistics published by the American Hospital Association in June. The survey did not include new hospitals that are not built yet or expansion of hospitals not registered by the American Medical Association.

Although hospital construction has been going ahead at a record rate, the unmet needs are nearly as great now as they were in 1945, according to the American Hospital Association. These needs are being revised constantly because of new concepts of medicine and hospital administration. The Public Health Service reports:

"At the beginning of 1951 in the United States and territories, there was a total of 1,185,480 hospital beds exclusive of those in hospitals operated by the federal government . . . 1,009,918 were appraised by state agencies as 'acceptable' . . . 873,569 additional beds are needed . . . Currently, therefore, the present supply of acceptable beds meets nearly 54 per cent of the nation's estimated total bed need.

"In the four years since construction was begun under the Hill-Burton program, there has been a net increase of 141,958 acceptable beds . . . Despite this net increase in existing acceptable beds, the decrease in the estimated net additional beds needed has amounted to only 34,872. The construction of new beds has proceeded at a pace slightly ahead of increasing needs due to population growth and the rate of obsolescence."

New Chief Medical Officer Named to Coast Guard

Dr. Joseph F. van Ackern has been appointed chief medical officer of the Coast Guard, it was announced by Dr. Leonard A. Scheele, surgeon general of the Public Health Service.

The new chief succeeds Dr. Paul M. Stewart, who has reached the age of mandatory retirement.

Dr. van Ackern has been medical officer in charge of the U. S. Public Health Service Hospital,

℞ *the prescription for your p.r. problem*

"At Your Service," . . . the series of thirteen 15-minute transcribed radio programs available to you through the library of the American Hospital Association. Programs cover "Nursing Service," "Voluntary Prepayment," "Hospital Costs" and other subjects of importance to hospitals. Provision for announcements about your own hospital at the end of each program. Rental fee for entire series, $5. Purchase price, $25. For further information, write to the

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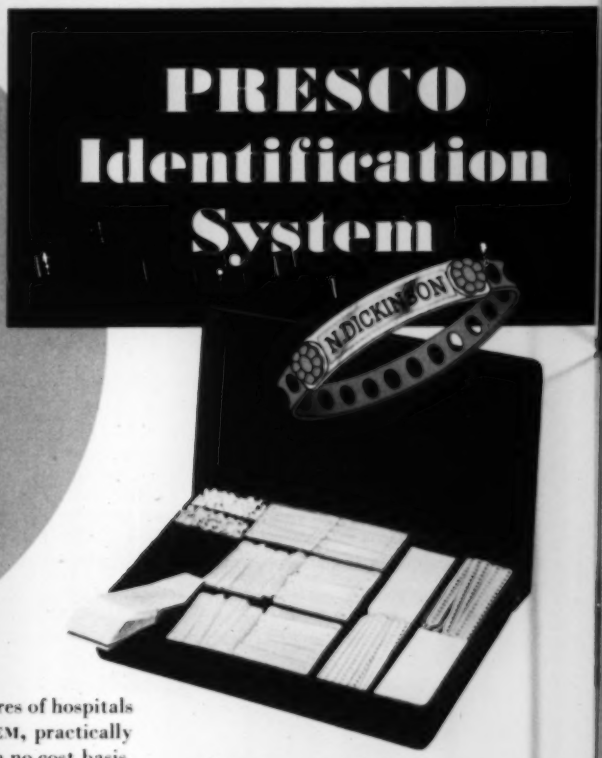

Pays Its Own Way...and More—Of the scores of hospitals that are using the PRESCO IDENTIFICATION SYSTEM, practically every one is enjoying its many vital advantages on a no cost basis. In fact, the vast majority are charging one dollar for the PRESCO bracelet after it has served its protective purpose and becomes a beautiful, priceless keepsake. Even at the minimum charge of fifty cents, each bracelet more than pays its own way.

Positive Identification—Easily and Quickly Applied

The PRESCO system is simplicity itself. A soft, pliable plastic bracelet (non-toxic to skin) is slipped around wrist or ankle. It does not have to fit tightly, yet stays comfortably and safely in place. On in a jiffy, with a minimum of preparation. And it won't come off until it is cut off.

The name card (which is slipped and automatically locked into the transparent bracelet) provides ample space on the back for additional data and fingerprint, if desired.

***for Free Samples** and the complete story, write the PRESCO COMPANY, INC., Hendersonville, N. C.*

PRESCO BABY KIT
(for baby identification) beautifully designed in durable plastic, contains 144 complete bracelets (72 blue and 72 pink) $5.95
(Adult size packed all pink, all blue, or all white; same price)

PRESCO REFILLS
144 complete bracelets, 72 blue and 72 pink, or all white for adults . . . $4.30

Adult Identification Important, too!

Adult size PRESCO bracelets are especially recommended for use in surgical cases and in multiple-bed rooms. They're a never-failing "double-check" in the cause of complete accuracy. Again, here's a protective procedure patients are glad to pay for.

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Costs So Little! Weighs So Little! *Offers So Much!*

Lightweight • The lightest all-purpose hospital screen ever designed—only 4½ pounds! So easy to lift or move or store.

Sturdy • One-piece tubular aluminum frame, anodized for lifetime satin finish. Glider base plus self-locking hinges make this screen virtually tip-proof.

Easily Maintained • Panels of durable Goodyear Vinyl require no laundering. They can be cleaned in a jiffy with light germicidal solution—without removing from frame. "Snap-out" curtain rods permit split-second replacement of panels.

Eye Appeal • Beautiful Vinyl panels in a variety of cheerful colors—blue-gray, pastel rose, pastel green, or white. Also, a new nursery design with gay circus characters. Satin-finish aluminum frame.

Flexibility • Exclusive design provides extremely compact folding. Can be used as either 2 or 3 panel screen.

Easily Stored • Folds to only 1½" thickness. Requires an absolute minimum of storage space.

Low Cost • Compare this PRESCO *feather-lite* Screen, feature for feature, with any other. Then compare costs. The PRESCO Screen, complete with Vinyl panels—only **$39.50**! Extra screen panels, **$2.00** each. (Without panels, **$36.00**)

Write *for swatches which show the true beauty of these Vinyl panels.*
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Milwaukee 12, Wisconsin

Seattle, Wash., since 1944. From 1939 to 1944 he held a similar position in the Public Health Service, Washington, D. C., Outpatient Clinic. As chief medical officer of the Coast Guard, he will hold the rank of assistant surgeon general.

In his new position, Dr. van Ackeren will plan and administer the general medical program pertaining to the health of Coast Guard personnel. Besides being responsible for the supervision of all physicians, dentists and nurses detailed to the ships and principal land installations under the control of the Coast Guard, he will serve as liaison officer between the Public Health Service and the Bureau of Medicine and Surgery, U. S. Navy.

Children's Cancer Clinic Opened in Chicago

A children's examination clinic to detect early stages of cancer was opened officially by the Cancer Prevention Center October 15 at Women and Children's Hospital, Chicago.

The new clinic, the first of its kind in the midwest, will be operated jointly by the Cancer Prevention Clinic and the hospital. Children brought to the new clinic for examination to reveal early cancer or precancerous lesions will be given a complete laboratory work-up and examination. A verbal evaluation of findings will be given to the parents and recommendations made for follow-up care. A report also will be sent to the family physician or pediatrician upon request, said Elise I. Biechler, administrator of Women and Children's Hospital.

Parents are asked to make the fullest use of the new department regardless of financial status, Miss Biechler added. A nominal donation of $5 will be asked and the additional cost of the service will be maintained by the examination clinic.

The purpose of a diagnostic and preventive clinic for children, according to Mrs. Arthur I. Edison, administrative director of the Cancer Prevention Center, is to help eradicate cancer as the third leading cause of death in children and to educate parents toward periodic health examinations of their children.

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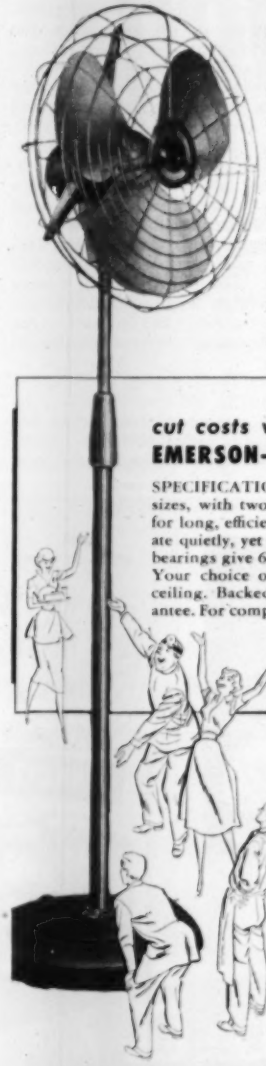

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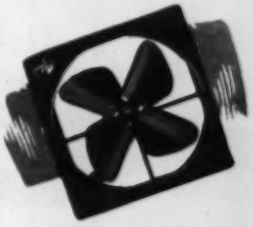
SPECIFICATIONS: Available in either 24" or 30" blade sizes, with two-speed, ball-bearing capacitor-type motors for long, efficient service. Full-type aluminum blades operate quietly, yet move a huge volume of air. Grease-packed bearings give 6,000 hours of service without relubrication. Your choice of four mountings: floor, counter, wall or ceiling. Backed by famous 5-Year Factory-to-User Guarantee. For complete information write for free Bulletin 7104



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Nurse Enrollment Shows Increase

Preliminary figures indicate that student nurse enrollment for fall classes this year will show an increase over 1951 enrollment.

The Committee on Careers in Nursing's August 15 Survey of Applications showed that 38,792 applications had been accepted with 3,054 pending. The total of accepted applications was based on returns from 873 schools which showed 28,816 applications accepted, and an estimated 9,976 enrollees based on 1951 admissions to 289 schools. The number of applications pending represents an actual report and is not an estimate.

As compared to the 1952 application figures, the committee reported that 1951 fall admissions totaled 37,188.

The Committee on Careers in Nursing will conduct another national campaign for student nurses in cooperation with the Advertising Council, Inc., to back up local campaigns. The American Hospital Association, as in past years, has contributed $10,000 to the national recruitment budget.

Advertising support contributed to the student nurse campaign from January to Sept. 15, 1952, through the cooperation of the Advertising Council utilized newspapers, radio, television, outdoor posters, car cards, three-sheet posters and national magazines.

There were 2,500 advertisements, the equivalent of 1,000 full pages, inserted in daily, weekly and foreign language newspapers. Approximately 500 editorial-type advertisements were displayed on preferred pages in May and in June by leading daily newspapers.

Virtually all major radio programs carried student nurse recruitment messages each month from January through June, and messages appeared on television programs in January and in May.

About 2,500 outdoor posters were posted in April throughout the country and about 90,000 posters were displayed in transportation vehicles across the nation in May. In June, some 7,000 three-sheet posters were displayed in railroad stations or on platforms, largely in metropolitan areas. In addition, student nurse recruitment messages were included in national magazine advertisements by several large companies.

Nursing Groups Outline Needs To President's Commission

The leading national nursing organizations have warned the President's Commission on the Health Needs of the Nation that nurses alone cannot solve the critical shortage of nursing service existing in almost every city and rural area in the country.

The warning was made in a joint

A Puzzling Problem?

You probably do have tough textile and garment problems at times. We cannot guarantee to answer them all. But we'll make all of our facilities, knowledge, and experience available to you. Since we have a unique mill to customer operation, we feel we're more qualified to help you than anyone else. Try us!

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Something Missing?

GENNETT CLEANERS UTILITY CART

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Go Gennett!

Model U-2
$54.00 list
F.O.B. Factory

Gennett and Sons, Inc.
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Richmond, Indiana

declaration to the commission by the American Nurses' Association, the National League for Nursing, the National Association for Practical Nurse Education and the National Federation of Licensed Practical Nurses.

Mrs. Elizabeth Porter, R.N., president of the American Nurses' Association, acting as spokesman for the four organizations, said that the declaration marks the first time on a national basis that the field of practical nursing had joined with professional nursing to act on basic over-all nursing problems.

Although the nursing organizations have taken action along many lines to solve the critical shortage, the joint declaration stated "they have neither the funds nor the authority to effect all the improvements and changes which are necessary."

The document calls for cooperation and support by national and state legislative and governmental bodies, by allied health professions and groups, and by "citizens who are the ultimate consumers of nursing service."

The nursing groups asked the President's Commission to give attention and recognition to three urgent needs:

1. More nurses, through support and promotion of recruiting to get qualified people to enter advanced, basic professional and practical nursing education programs, and economic security for nurses to attract and keep workers in nursing.

2. Better nurse power, through support and promotion of improvement of schools by measures to provide for better curriculum, faculty preparation, and material resources; state legislation which will provide for the licensure of qualified professional and practical nurses in order to protect the public and facilitate interstate movement of licensed nurses.

3. More effective use of nurses through support and promotion of better administrative practices in nursing service; elimination of discrimination in the selection and terms of employment of nurses because of race, color, or creed; improved distribution of nurses and organized nursing services in the community.

The three-point proposal is backed up by 21 specific recommendations, ranging from such measures as provision of funds for nursing education, surveys of employment conditions, studies of

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IT'S QUIET! Only one patient hears the Dahlberg *Controlled-Volume* Pillow Radio.
NEW COLORS! Blend with room decoration.

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nursing functions and resources, legislative reforms, research and experimentation in nursing education and service, streamlining of nursing administration, to extension of nursing service in prepaid health care plans and public medical care programs.

Pamphlet for Layman Explains Nursing Education of Today

A new pamphlet, "Preparing Tomorrow's Nurses," has been completed by the Public Affairs Committee in cooperation with the National League for Nursing, and is available to interested groups or persons.

The booklet points out why nurses need a real education if they are to give good service, and what the public can do to help correct some of the shortcomings in the present day preparation of nurses.

It presents information about nursing service and education today, and describes the enlarging scope and increasing complexity of nursing and the changing patterns of nursing service. It traces the history of schools of nursing in the United States.

The pamphlet, written especially for the layman, is designed as a tool in explaining nursing education to the press, legislators, boards of directors and members of committees concerned with nursing, members of community and civic clubs, educators, physicians, parents, and all other present and potential users of nursing service.

Copies may be obtained at small cost from the National League for Nursing, 2 Park Ave., New York 16.

Academic Program Changed at Iowa Nursing College

Two changes in the academic program of the State University of Iowa College of Nursing have been announced. The changes involve the elimination of the three-year diploma program in nursing and the formulation of a one-year demonstration program designed to provide an adequate supply of practical nurses for Iowa and surrounding states.

The dean of the college of nursing said that the students accepted into this year's diploma program will be the last ones admitted. The three-year course is being dropped, the dean said, because of a decrease in students seeking such a course and a corresponding increase in students seeking the four-year degree course offered by the college since 1949.

The four-year course offers the opportunity to combine a liberal arts education and a nursing education, the dean added, with the student graduating with a bachelor of science degree as well as a certificate in nursing.

Michigan University Reports High Nursing Enrollment

Freshman enrollment in the University of Michigan School of Nursing has increased sharply since the announcement of the school's new four-year degree program.

Prof. Rhoda Reddig, school director, points out that this year's freshman class of 151 is the largest in the history of the school. The new curriculum offering a four-year program leading to a bachelor of science degree in nursing "has captured the interest of young women throughout the country," she says.

U.M.W.A. Fund Considers Nurse Training Program

Officials of the United Mine Workers' Welfare and Retirement Fund are giving serious consideration to instituting training of nurses and practical nurses in some, if not all, of the 10 hospitals which are to be erected in mining areas with funds lent by the fund.

Structural, operational and other details of the miners' hospitals have been carefully guarded. The plan for nurses' training, however, leaked out when a model of the hospital to be erected in Harlan, Ky., was exhibited at the U.M.W.A. convention in Cincinnati in the first part of October. The model included provision for a student nurse dormitory. Subsequently, U.M.W.A. spokesmen in Washington confirmed that they are carefully studying the launching and maintenance of training programs for nurses and practical nurses.

Directly in charge of planning and development of the hospital program is Roy Hudenburg, formerly secretary, Council on Hospital Planning and Plant Operation of the American Hospital Association.

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New York Plan Awarded "Oscar of Industry"

The 1951 report of Associated Hospital Service, New York City's Blue Cross plan, was rated first in the health insurance field by the publication, "Financial World," in its 12th annual survey of annual reports.

A bronze "Oscar of Industry" trophy, in recognition of the rating, was presented to Charles Garside, the plan's president, at a banquet October 28 in New York.

Runner-up for top honors in the health insurance industry classification was United Medical Service, New York's Blue Shield plan.

Management Pays 1.4 of Payroll for Life-Health Insurance

American employers are paying almost a billion and a half dollars a year for employee health and life insurance benefits, according to a U. S. Chamber of Commerce survey of "fringe benefits," or labor costs not shown on the actual payroll.

The survey, taking in 736 companies, is the third study by the chamber in this field. It groups together "life insurance premiums, death benefits, sickness, accident and medical care insurance premiums, hospitalization insurance, etc.," and established that they cost management an amount equal to 1.4 per cent of its total payroll. Because many companies purchase combined life-health insurance, no breakdown between the two could be made.

An indication of the rapid increase in employer financed life-health insurance in the last four years is the fact that the average company now pays exactly as much for these particular items as for Old Age and Survivors Insurance.

Inter-Plan Bank Handles Record Number of Cases

During the third quarter of 1952, the Inter-Plan Bank again set new records for volume of business processed with a total of 50,745 cases cleared during July, August and September. This was 7,820 cases more than the previous high figure set in the second quarter.

Third quarter days of care rendered numbered 357,115.5 days, which was 47,121.7 days more than the second quarter high.

the new HILL-ROM Post Anesthesia Bed

This new Hill-Rom Recovery Bed has a removable footboard and provision for the insertion of regulation knee crutches, making possible its use as an emergency delivery bed. There are six positions for the Irrigator Rod—two behind the headboard, two at the foot end, and two at the seat section of the bedspring. One adjustable double hook Irrigator Rod is supplied with this bed.

The bed is 33" wide x 86" long (overall) and is equipped with wide casters, four brakes, and a 30" wide end crank heavy duty Trendelenburg spring with mattress guard attached. The sides are anodized and finished with baked-on enamel, and operate the same as a crib.

Illustrated folder and complete information sent on request.

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TWO OTHER HILL-ROM FIRSTS!

new

Safety Side —easily attached to head end of bed. Light weight (7 lbs.) makes it easy to attach and adjust on any wood or metal bed. Does not interfere with making up bed or use of overbed table. Will take care of 98% of all cases.

new

Safety Step —easily attached to either side of any hospital bed—wood or metal. Entire weight is carried on floor—no strain on bed rail. Routinely kept in down position—easily raised out of way with touch of toe.

Average length of stay of Blue Cross Bank patients was 7.31 days, compared with 7.66 days during the third quarter of 1951.

During the third quarter, the bank paid hospitals $5,217,921.88 for the care of Blue Cross members hospitalized out of their area, as compared with $3,627,787.95 paid in the same period in 1951, an increase of $1,590,133.93.

The 87 Blue Cross plans paid a total of $287,457,690 for hospital care of Blue Cross members during the first six months of 1952. Operating expense during this period dropped to an all time low of 7.60 per cent of total income.

Hospital Costs Increase in Central Pennsylvania

According to latest figures released by Capital Hospital Service, Inc., the Blue Cross plan in Harrisburg, Pa., the cost of hospital care for Blue Cross members in central Pennsylvania during the first eight months of this year amounted to almost $5,000,000.

The figure represents 92.6 per cent of the total income, reported Clement W. Hunt, executive director of the plan.

"Experience for the year so far indicates that income earned from our present subscription rates may not continue to be sufficient to cover the plan's obligations," Mr. Hunt said. He added that the proportionate number of Blue Cross members being hospitalized has increased more during this past year than in any recent year.

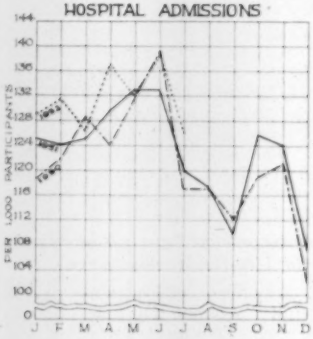
A report for the month of August revealed that almost 7,000 members were hospitalized at a cost to the plan of $569,779.

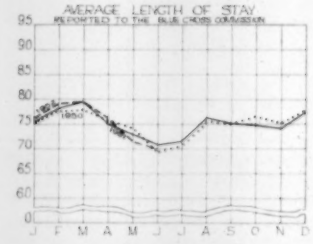
Illinois Hospital Begins Aide Training Course

Faced with a nursing shortage, the Evanston (Ill.) Hospital has announced the opening of a training course for men and women interested in becoming senior nurse aides.

Arkell B. Cook, administrator, said the program will include instruction in a large number of nursing duties which aides can perform under the direction of graduate nurses.

The aides, who will earn as they learn, will receive 240 hours of training during a six-week course devoted both to lectures and to floor duty. Included in the instruction will be nursing arts, surgical and pediatric nursing, mother and infant care, and medical nursing.



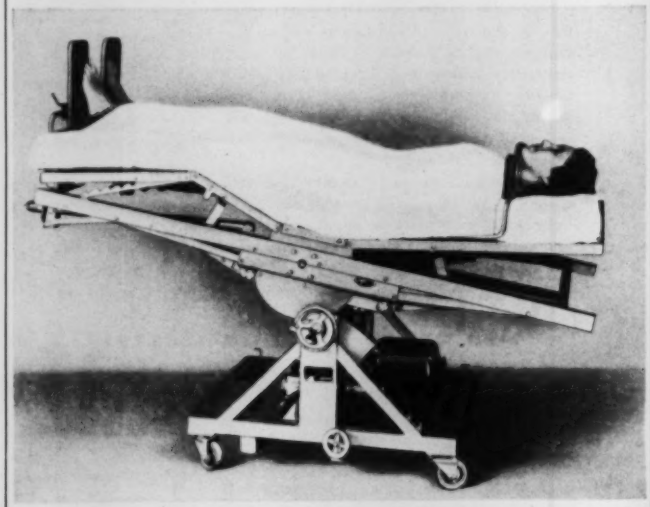


ADMISSION-STAY

During July, Blue Cross members were hospitalized at the annual rate of 126 inpatients per 1,000 participants. This represents a decrease of 12 per 1,000 participants, or 8.70 per cent, from the June rate.

Following past trends, Blue Cross plans experienced a decrease in the average length of stay during June. Stays of hospitalized members averaged 7 days during June 1952, and were shorter in duration than stays during the same month in the last five-year period, with the exception of June 1950.

Blue Cross plans provided an average of 937 inpatient days of care per 1,000 participants during June, marking only a slight increase of 0.64 per cent over the May experience. Compared to the same month of earlier years, the number of inpatient days of care provided by the plans during June 1952 was less than 1949 and 1950, but higher than 1948 and 1951.



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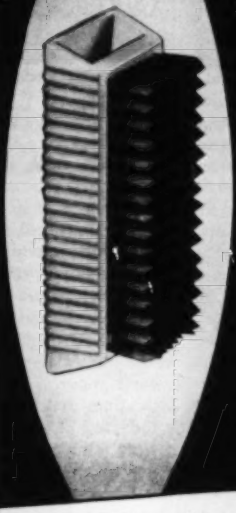

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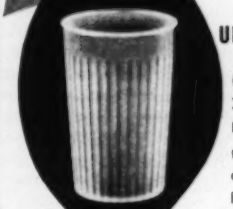

ANCHOR NYLON UNBREAKABLE TUMBLER

Rigid nylon construction • Full 7 oz. size • Stain-resistant. Ribbed surface for non-slip grip • Can be autoclaved or boiled • Furnished regularly in translucent white. Also available in pastel shades (blue, pink, green).

ANCHOR TUMBLERS COMBINE ECONOMY WITH SMART DESIGN

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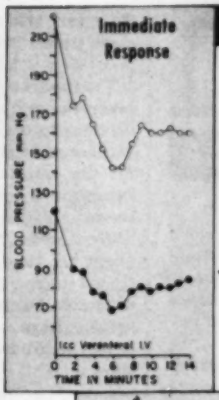
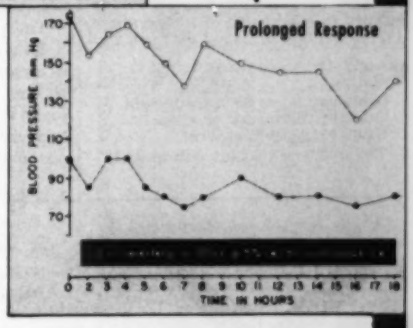


Verenteral acts quickly dramatically safely



Verenteral*

IN SEVERE PRE-ECLAMPSIA AND ECLAMPSIA

The introduction of Verenteral in the management of severe pre-eclampsia and eclampsia has proved to be a lifesaving measure. In a series of more than 200 cases, the intravenous infusion of Verenteral was a decisive factor in the control of convulsive eclampsia.

Verenteral, a biologically standardized extract of Veratrum viride, is the first sterile intravenous Veratrum viride preparation for the management of pre-eclampsia and eclampsia. Verenteral produces a marked arteriolar vasodilatation with a consequent drop in blood pressure. The vasodilator effect of Verenteral is the decisive therapeutic response that results in the control of the disease and restores the patient to a stage where delivery can be accomplished.

Each cc. of Verenteral contains 100 C.S.R. (Carotid Sinus Reflex) Units of Veratrum viride, Biologically Standardized. Supplied in 20 cc. vials.

* *Brand of Veratrum Viride Extract (Irwin-Neisler).*

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PRO RE NATA

JOHN H. HAYES

Contrary to the idea of some years ago, there is nothing wrong in a hospital statement that shows a surplus, after deducting expenses from the total receipts from patients and philanthropy.

True, a hospital is appraised by what it contributes to the community in the health of the people. All of us ought to show in our reports these contributions:

Depreciation on buildings.
Depreciation on fixed equipment.
Value of volunteers' services.
Value of doctors' services.

The average surplus will quickly disappear when balanced against these items.

★ ★ ★

Twenty years ago we equipped several operating rooms with connections to our radio system, with earphones to the operating tables, for the entertainment of patients being given local or spinal anesthesia.

We used the darned things about six times and then discontinued them. No one has as yet suggested putting television on operating room ceilings so that patients might look at it, or a floor show.

★ ★ ★

There oughta be a law.

Situated as our hospital is, in a crowded city, parking of cars is one of our big problems. To make matters worse, our neighbors and visitors double park alongside our doctors' cars, at times making it necessary for our doctors to use taxis because their cars are blocked in.

We are on a subway station street. Auto commuters park their cars on the four streets around us in the early morning, take the subway to work and come back in the evening.

I am told that there are 2,500,000 cars and trucks in New York City, and parking and garage space for only 500,000 cars.

If we had the privilege of giving tickets and collecting fines on our four streets, I figure our take would be about $180,000 per year, or about half our operating deficit. Of course, if we were permitted to do this, the parking problem would soon cease to exist—and that might be worth more.

It takes a little time, but saves lots more—the indexing of actions of board of trustees' and committee meetings each year. This also applies to medical board minutes. Quite often we are asked to look up a ruling made sometime in the past. It takes a long time to find it.

★ ★ ★

Do you suppose that many patients fall out of bed, due to the "early ambulation" fad?

★ ★ ★

There are at times wealthy persons who find, on the last day of the year, that they can, from a tax angle, give more to hospitals, but want their bank accounts charged as of the year just ending.

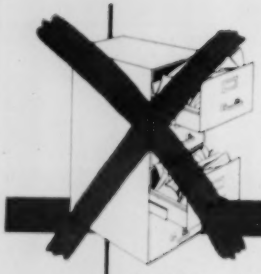
Here's the way they can do it, even after banking hours: Ask their bank to issue to them a cashier's check in the amount of the gift. This immediately is a charge to their bank account, no matter when the charity clears it through its bank. Contributors can even prepare ahead for this; and, if they find later that they cannot afford it, redeposit the cashier's check to the credit of their own accounts.

★ ★ ★

Pat Pending, our crackpot inventor, has a new one—a bedside chair for visitors that can be set so that it collapses at the end of one hour. Then they will sit on the beds.

★ ★ ★

Someone once said that 95 per cent of the people are honest. If



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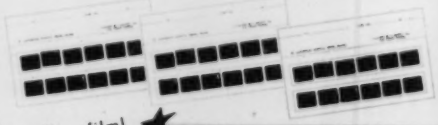
Wouldn't you like to have one file cabinet do the work of fourteen or more? Filmsort, saver of space and time in your hospital medical library, does just that for you.

Surveys in the Defense Department medical centers show that Filmsort Jackets in one four-drawer 8½ x 11 file cabinet would hold the records formerly in fourteen such cabinets.

Filmsort reduces your voluminous case histories and x-rays to microfilm, then individualizes the film by case history into Filmsort Jackets.

Think of the space and the time Filmsort saves. Think of the buried treasure in your file cabinets that you can unearth when you use Filmsort.

Send for literature, no obligation of course.



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"back care cannot be overemphasized"[1]

Hand in hand with the growing practice of budgeting the nurse's time has come recognition that the lotion chosen for patient skin care and massage CAN MAKE A DIFFERENCE. To gain maximum results for the effort expended, hospital executives, physicians and nurses are turning increasingly to

[1]NURSING ARTS, Mildred L. Montag, M.A., R.N., Margaret Filson, M.A., R.N., Saunders, 1948, p. 237

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dermassage
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for massage and bed sore prevention measures—Now with ANTISEPTIC VALUE

The soothing, emollient character of Dermassage, the protective value added by germicidal hexachlorophene and the cooling effect of menthol—these combine to make Dermassage a logical aid to patient skin care. The lanolin and olive oil content lubricates skin surfaces, reduces likelihood of cracks and irritation. Hexachlorophene minimizes the risk of initial infection, gives added protection where skin breaks occur despite precautions. Menthol refreshes without resort to rapid, skin-drying evaporation.

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Your request for enough copies to fill your requirements will be filled promptly.

a liberal trial supply of Dermassage for hospital use will be sent on request—COMPLIMENTARY, PREPAID!

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that is so, why wouldn't this be worth trying: Furnish the patient, or his family, with a statement reading somewhat as follows:

"It costs this hospital an average of $17 per day to care for a ward patient.

"We believe you want to pay this cost, or as much of it as you can afford. We do not ask more.

"Therefore, will you please fill in below the amount you can pay.

"For the first week $ _____.

"For the second week $ _____.

"Per day thereafter, if necessary $ _____."

You could then avoid asking as to salary, rent paid, number of dependents, etc.

If any of you try it out, please let me know how it works. I'm a bit shy.

* * *

There is no truth in the rumor that the bedpan was invented at the time of the Spanish Inquisition.

* * *

About house organs: They can do much, I believe, to weld together the workers in any organization; but I sometimes wonder whether or not they sometimes have the opposite effect. For instance, mention of marriages, condolences at times of death in a worker's family. It is nice for those mentioned, but you are bound to overlook others. That means hurt pride or even resentment. If you do not mention any, no one is provoked.

This also applies to the mention and comparative amount of space given to a department, an auxiliary, etc. The editor of a house organ has a tough job; and he gets very little appreciation.

There is an old saying, "I don't care what you write or say about me, so long as you mention my name." Most people like publicity; and so long as you do not overlook anybody, or any group, everything is fine.

A house organ is like a church organ. It takes a lot of wind to keep it going.

* * *

Patients have told me that when they first were allowed to "dangle their legs" over the side of the bed they felt as though they were on top of the Empire State Building.

you can't go wrong
when you reach for
EDISONITE
surgical cleanser
BOTH POWDER AND SOLUTION

now colored CRYSTAL GREEN for positive identification

NOW turn the task of instrument cleansing over to EDISONITE SURGICAL CLEANSER—and save costly nurse-hours for tasks that only nurses can perform!

EDISONITE dissolves debris clinging to instruments in a 10- to 20-minute immersion. Leaves metal, rubber or glass thoroughly, chemically clean. Also

Edisonite now gives that extra measure of protection...

—because it is colored Crystal Green to eliminate any possibility of error in identifying liquids. Instruct surgical personnel to "Reach for Crystal Green EDISONITE, and cleanse instruments *safely*!"

It costs you nothing to give EDISONITE this performance test

If EDISONITE cleansing is not yet routine procedure in your surgical and emergency departments, write for our 5-lb. TRIAL PACKAGE—sent COMPLIMENTARY AND PREPAID. Then test EDISONITE thoroughly under all conditions!

Your Distributor or Write

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STATEMENT OF THE OWNERSHIP, MANAGEMENT, AND CIRCULATION REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946 (Title 39, United States Code, Section 233)

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1. The names and addresses of the publisher, editor, managing editor, and business managers are:

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BREMEN I. JOHNSON
Business Manager.

Sworn to and subscribed before me this 25th day of September, 1952.

[SEAL]
BEULAH DEEKEN,
Notary Public.

(My commission expires February 15, 1954.)

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ADMINISTRATORS—NURSES: (a) Beautiful, new hospital recently completed; voluntary, general, 90 beds, near university center; New England. (b) Hospital for crippled children; should be qualified to develop expansion program; minimum $6500, maintenance; university medical center; Midwest. (c) New community hospital to be completed January; residential town, South. (d) Assistant administrator by successful nurse administrator. FACHA: lay administrator eligible: 300-bed general hospital; expansion program; large city, university medical center. (e) Administrator to serve as director of professional relations, rehabilitation center, East. H11-2.

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DIRECTORS OF NURSES: (a) Voluntary general hospital; average census, 300; 90 students; departments well staffed; outstanding medical staff; California. (b) University school; women of outstanding qualifications, Master's or Ph.D., qualified develop four-year program; $7000-$8000 (c) Voluntary general hospital recently completed, 300 beds; school within year; college town, South. (d) Nursing service new hospital currently under construction; completion Midwinter; vicinity New York City. (e) Nursing service; 600-bed university hospital; although independent administratively from dean and faculty of school, highest degree cooperation between school and service; substantial salary including complete maintenance, private apartment. (f) To succeed director of nursing service retiring after nineteen years' tenure one of most important and progressive hospitals on the Pacific Coast. H11-5.

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REGISTERED RECORD LIBRARIANS—(a) Chief; university hospital; unit of important university "teaching" medical center; large city of south.

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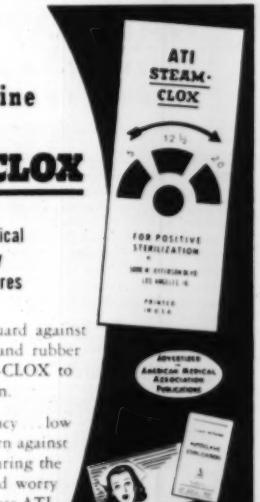

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POSITIONS WANTED

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BUSINESS MANAGER-COMPTROLLER: 15 years' executive experience large metropolitan hospitals. Organizer. Systematizer. Economizer. Will relocate. Address Box D-79, HOSPITALS.

Hospitals in the state of Pennsylvania—ATTENTION—I am a particular man looking for a particular position as hospital director, preferably in a small town in the state of Pennsylvania. I have spent twenty years of my life preparing for it in some of the best known hospitals in this country. I am at present 44 years old, married and want to settle down in a small town for the rest of my life. For interview, please contact L. W. Hammett, 3700 North Charles St., Baltimore 18, Md., Phone Hopkins 8423.

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ACCOUNTANT—B.S. (Accounting and Economics); six years, accountant, 600-bed hospital.

ADMINISTRATOR—Medical; sixteen years, administrator, large teaching hospital during which time for seven years served as professor of Hospital Administration; FACHA.

ADMINISTRATOR—Lay; B.S. (Business Administrator); since 1942, director, voluntary general hospital, 350 beds; excellent experience in planning hospital facilities, fund raising; FACHA.

ADMINISTRATOR—B.B.A., M.B.A. (Hospital Administration); year's administrative residency, teaching hospital; three years, assistant administrator, voluntary general hospital, 250 beds.

ADMINISTRATOR: Graduate nurse; Master's (Hospital Administration); administrative residency, teaching hospital; four years, administrator, 65-bed hospital.

PATHOLOGIST: Diplomate (Pathologic Anatomy and Clinical Pathology); FCAP; eight years, director, pathology; 300-bed hospital and associate professor of pathology, university medical school.

PERSONNEL DIRECTOR—Bachelor's in Business Administration; year's administrative internship, teaching hospital; two years personnel director, 300-bed hospital.

PUBLIC RELATIONS DIRECTOR: B.A. degree; six years, director of public relations during which time he conducted campaigns for important hospitals throughout country.

RADIOLOGIST—Diplomate (Diagnosis and Therapy); six years, director radiology, voluntary general hospital, 300 beds; six years, chief of department, teaching hospital and associate professor of radiology, university medical school.

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ADMINISTRATOR—Lay R.N., B.S., five years, educational director; four years, superintendent of nursing; past ten years, administrator, 500 bed general voluntary hospital; FACHA.

ADMINISTRATOR—Lay Male R.N.; two years, assistant administrator, teaching hospital; six years administrator, 125 bed voluntary general hospital.

ADMINISTRATOR—Medical; six years, Commanding Officer, several military hospitals; past six years, director, 800 bed general hospital. Member ACHA.

ASSISTANT ADMINISTRATOR—B.S., business administration; 10 years personnel officer, 1200 bed hospital; four years, assistant administrator, general hospital, 500 beds; seeks assistantship very large hospital or administrator, hospitals 100 beds. Middle thirties; Member, ACHA.

ANESTHESIOLOGIST—Diplomate, American Board Anesthesiology; past six years, Chief, department of anesthesiology, V. A. hospitals; particularly well qualified to reorganize department.

ANESTHESIOLOGIST—draft exempt; early thirties; past three years, Chief; general hospital, 300 beds; salary, percentage or fee-for service basis; prefers southeast.

PATHOLOGIST—Diplomate, pathologic anatomy, clinical pathology; three years, associate pathologist, university hospital; 2 years, assistant professor, pathology, university medical school; past 2 years, director, pathology, general voluntary hospital, 200 beds; seeks larger hospital; middle thirties.

RADIOLOGIST—30; category IV; certified in both branches; past year private practice of radiology; small town limits income; any locality.

RADIOLOGIST—Certified in both branches; category IV; highly qualified X-Ray physics-radioisotopes six years. Chief of X-ray, 500 bed teaching hospital and professor university medical school; early forties.

INTERSTATE
MEDICAL PERSONNEL BUREAU

332 Bulkley Building, Cleveland, Ohio

Miss Elsie Dey, Director

ADMINISTRATOR: B.S. Degree, Univ. of Michigan. 4 years Registrar, V.A. Hospital. 7 years experience. 150 bed mid-western hospital.

ASSISTANT ADMINISTRATOR: M.H.A. Degree, 1949. 2 years Residency; Administrative Assistant. 1 year Personnel Director.

BUSINESS MANAGER: B.S.C. Degree, 6 years accountant, business firms. 3 years Assistant business manager, large Iowa hospital.

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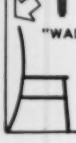

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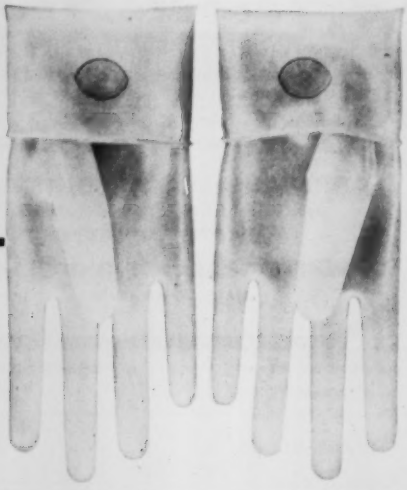

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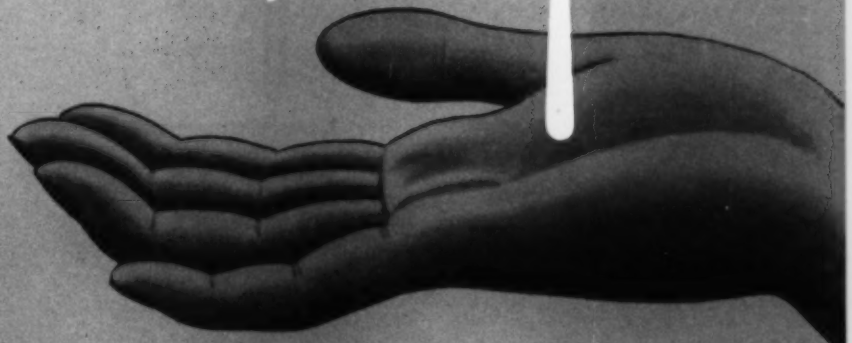

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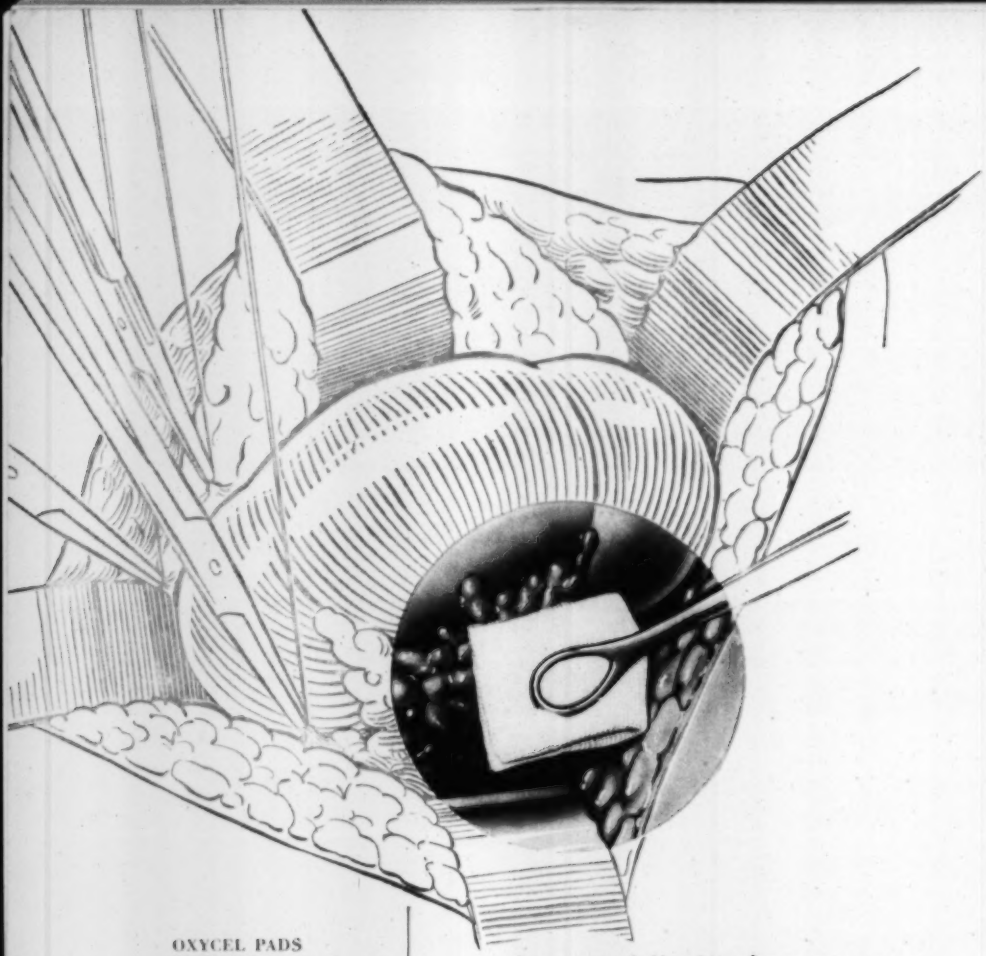

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